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CONTENTS.

EDITORIAL.

The Menace to Public Health from the Use of Contaminated Drinking Water, 35.

OVERHEARD, 36.

ORIGINAL ARTICLES.

Intra-Pelvic Operations for Relief of Posterior Uterine Displacements. Walter B. Chase, M. D., 37.

Irreducible Incarcerated Retroflexed Gravid Uterus, 39.

Popular Ignorance Respecting Medicine. John Williams, M. D., 40.

CURRENT MEDICAL LITERATURE.

Les Lois de l'Énergétique dans le Régime du Diabète Sucre, 41.

Ueber Wesen und Ursache der Zuckerkrankheit, 42.

Some Questionable Views on Diet, 42.

The Prevention and Treatment of Obesity, 43.

The Universal Illusion of Free Will and Criminal Responsibility, 44.

LEADING ARTICLES.

Olive Oil in Typhoid Fever. Owen F. Paget, M. B., 45.

Treatment of Gouty Eczema. Gilbert John King Martyn, M. D., 45.

The Treatment of Chronic Diseases. Burton G. Thomas, M. D., 46.

Complete Transposition of Viscera, 48.

Surgical Emphysema of the Eyelids, 48.

Methylene Blue as a Analgesic, 48.

Bromide Sleep in a Case of Mania. Philip M. Ragg, M. B., 49.

Liquor Thyroidei in Hæmophilia. C. Royds Jones, M. D., 50.

Advantages of the Spray in Pseudo-Membranes of the Pharynx. D. C. Brown, M. D., 50.

Apomorphine as a Hypnotic. E. W. Adams, M. D., 51.

BOOK REVIEWS, 51.

TOPICS OF THE HOUR.

Traumatic Joints, 52.

Irritable Breasts, 53.

Chorea in Children, 53.

Treatment of Pelvic Inflammation, 53.

Laparotomy for Typhoid Perforation, 54.

Acute Cervical Lymphadenitis, 54.

ARCHIVES OF GYNECOLOGY, OBSTETRICS, AND PEDIATRICS.

An appreciation of Pryor's Method of Removing the Fibroid Uterus by the Abdomen, with Report of Ten Successive Successful Cases. A. Laphorn Smith, M. D., 55.

Some New Methods in Pelvic Operations in the Female, 56.

The Treatment of Diphtheria by Iodine. Hugh Taylor, M. D., 57.

Subcutaneous Symphysiotomy, 57.

Retroflexion of the Gravid Uterus, 58.

A Case of Complete Inversion of the Uterus. David Durran, M. B., 59.

A Drop of Opiate for the Baby, 60.



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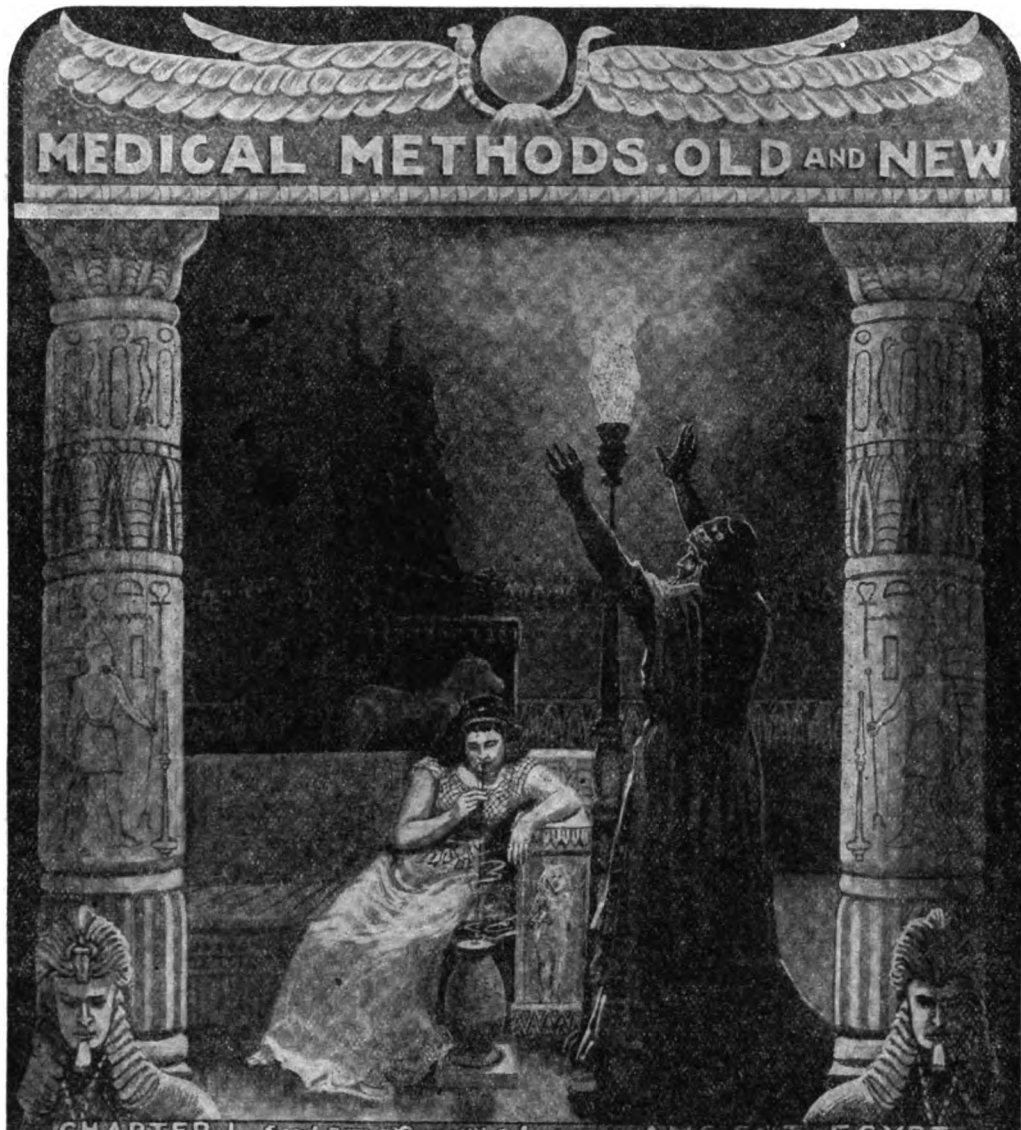
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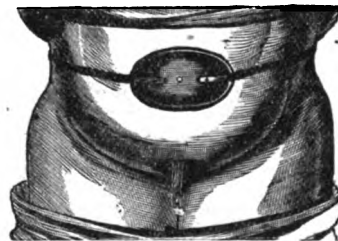
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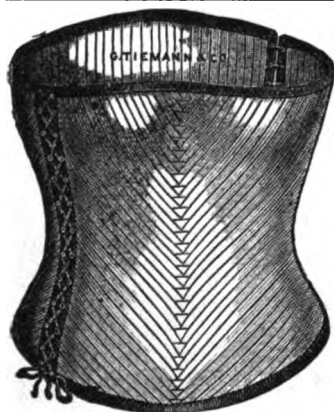
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NEW YORK LANCET

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The Menace to Public Health from the Use of Contaminated Drinking Water.

Though the subject is large and its thorough treatment can hardly be included in the columns of a medical journal, a few points that will scarcely fail to be of general interest may nevertheless be brought forward for consideration. It is not many years since, when a specimen of a water supply was taken to a chemist and if no extraordinary amount of sulphates or of albuminoids could be readily found, the managing board congratulated itself that the purity and excellence of such water was beyond question. Within the last decade or so other deleterious factors have been brought to the attention of public authorities. The surroundings of the lakes or ponds from which the water is taken, and the sources of the brooks, streams, or rivulets leading to the storage basins, have been subjects of special consideration and of legislative action.

Notwithstanding such careful study, the sewage of a country town or village, as too often happens, may gain admission into some of the branches of the supply, and thus become the source of grave consequences. The progress of trade and the marts of commerce, while affording an increase of comforts and conveniences, have been productive of danger. The erection of factories for the manufacture of cloth, the establishing of tanneries, and sometimes of a slaughter-house along the watercourse, and in the vicinity of the furnishing supply, have added

materially to the contamination. It is only quite recently that some of the Massachusetts towns have been relieved from the defiling influences of ice companies, that claimed control of that commodity, and so had employed large numbers of men and teams in cutting, taking, and hauling the yearly stores of ice from some of the best storage basins for domestic water.

The difficulty in tracing the contaminating influences of drinking water in the production of typhoid fever, intestinal disorders, and of other preventable diseases is often very great, especially when the cases are sporadic or are not of general interest. That different forms of bacteria may be conveyed in water is well proven by experimental tests made in Massachusetts on the Lawrence city water taken from the Merrimac River for determining the presence and absence of the bacillus coli communis. The object of entering upon the work was to ascertain whether sand filters would remove the same percentage of the bacillus coli communis that they do of the total number of bacteria present in badly polluted water. According to the State report of 1898-99 the typhoid germ is never found unaccompanied by the colon bacillus, although the reverse was found far from being true. It was assumed that for every typhoid bacillus in a polluted water that there may be many thousands of the variety of bacillus coli. The experiment tended to show further that a sand filter removes a much larger percentage of typhoid germs from water than of the bacillus coli. The experiments at Lawrence and elsewhere along such a line of investigation are most important, and thus establish the fact that the purification of drinking water can, by the use of sand and other filters, be largely effected.

All experiences of the careful observer become most convincing that the individual water consumer should not rely wholly upon the management of a water board for the purity of the supply. Every household should recognize that strict measures for sterilizing water for domestic

use should be employed. No uncultivated taste and no unaccustomed methods should stand in the way; these should be overcome that one's life and health, as well as those of others, may not be lost through neglect.

Another source of danger to the water-takers will soon have to be met, on account of an effort being made on the part of some water boards to introduce the meter system. While the use of meters supplied by gas and electric-light companies may be highly proper, any devices for measuring and limiting the proper amount of drinking water should be condemned, for such expedients would be a menace to the public health. A free and frequent flow of water out of the supply pipes and into the sewers should already be encouraged as a measure of great sanitary importance. The shutting off of the water supply at night and at other intervals, as has been done in some of the English and other towns, has not unfrequently been followed by an increase of typhoid fever and of other preventable diseases. It is only of late that in Massachusetts, and in some of the other more advanced commonwealths, the larger municipal water supply has been protected from the contaminating influences resulting from boating, swimming, and skating. Fishing in all such sources of water should also be interdicted. It is true that the health and sanitary boards have to act second to the operations of great financial projects; perhaps such subordination as a general procedure is not improper. But when the lives and health of a whole community are to be put in jeopardy, the officers of the public health should be active in sounding the proper note of warning and of seeing that their advice is listened to and respected.

Overheard.

Success in medicine, as in some other profession, means survivorship, and survivorship usually means a good physique. A man with feeble health may be a great preacher, a great lawyer (though I can hardly imagine him to be a great pleader), a great writer, or a great scientist, but he cannot be a great medical practitioner, for disease and suffering recognize no office time or any day of eight hours. The medical man must

be ever ready and ever active and must know no fatigue.—Sir John Williams, M. D.

♦

The littering of the doorsteps of the city and suburbs with suggestive and vile "medical" advertising pamphlets is a nuisance that should be abolished by the authorities.

♦

Dr. Knopf (Berlin) referring to the pneumatic cabinet, which has been extensively used in America, expresses the opinion that the use of the cabinet is of considerable value in the treatment of phthisis, especially at places of low altitude. A patient placed in this cabinet, when the pressure is reduced, experiences after some temporary embarrassment a greater freedom of respiration, and Dr. Knopf believes that the air penetrates more freely into the lungs. A course of this treatment diminishes anæmia and the tendency towards pulmonary congestion while increasing the development of the pectoral muscles. He believes also that if care is taken to make the patient breathe through the nose—a point to which in all cases he attaches much importance—the treatment is of value in laryngeal tuberculosis.

♦

The influence of syphilis in the production of alarming disorders of the nervous system is a subject dealt with by Dr. J. L. Steven in a recent lecture. The first case was one of syphilitic hemiplegia with Jacksonian epilepsy in a man, aged forty-six years, probably due to a gummatous affection involving the motor cortex. There were also present gummatous tumors of the scalp. Rapid recovery took place under mercury and iodide of potassium. This case reminds the reviewer of a similar case under his care which pursued a very varying course under anti-syphilitic treatment. Trephining was eventually had recourse to, but unfortunately this patient succumbed and a localized gummatous affection of the meninges and cortex of one Rolandic area was found. The second case was one in which several of the eye muscles were involved and there was severe hemiparesis. Complete recovery ensued under treatment with iodide of potassium and mercury. In the third case, of a man, aged forty years, there were motor aphasia and marked paresis and rigidity of the right arm and hand, preceded by severe headache. There was reason to believe the disease to be of syphilitic origin, but no improvement followed anti-syphilitic treatment. The last case occurred in a man, aged thirty-seven years, who had severe and protracted headache with alarming convulsions and mental derangement of undoubted syphilitic origin. The headache and fits were relieved by prolonged mercurial treatment.

Intra-Pelvic Operations for Relief of Posterior Uterine Displacements.*

WALTER B. CHASE, M. D.,

Brooklyn, N. Y.,

Consulting Gynecologist and Obstetrician to the Long Island College Hospital of Brooklyn and Consulting Gynecologist to the Hospital of Hempstead.

The number of cases of uterine retroversion and retroflexion which cannot be relieved by pelvic massage or mechanical support is numerous. Added to these are a class of cases in which adhesions, more or less strong, preclude safe replacements by any method short of opening the peritoneal cavity and cutting these adhesions. The suffering and the measure of incapacity these posterior fixations of the uterus entail admit of a wide degree of severity. In one case the patient suffers but little; in another the same apparent physical condition produces invalidism, appearing in a variety of symptoms too familiar to require repetition. Coincident with this, and so closely related to it as to often baffle perfect differentiation as to its ætiology, is a train of reflex phenomena manifested through the sympathetic nervous system, which adds to the patient's discomfort and serves to complicate the ends to be accomplished by rational treatment.

Added to this in not a few cases is the barrier this condition offers to reproduction. The fixation of the uterus effectually prevents the ascent of the gravid uterus, and as a result abortion or premature labor follows. So far as reproduction is concerned the consequences are the same as sterility. The reasons which prompt those so suffering to seek relief are twofold, first, and most frequently the pain and the impairment the condition imposes, and, as a second consideration, the desire of motherhood.

The principles which guide in the management of these cases form the theme to which I briefly invite your consideration. Experience and judgment must decide as to the wisdom of interfering in a given case. Not every case of posterior fixation of the uterus justifies resort to laparotomy for its relief, while some cases will respond to none but radical measures. In this discussion I shall not refer to the Alexander operation, for its field of usefulness is in cases of retro-displacements, in which reposition is not precluded by adhesions; neither will reference be made to ventro-fixation as a remedy in procidentia.

If the abdomen is opened to correct the displacement, one of three methods may be adopted, viz., intra-pelvic shortening of the round ligaments, ventro-fixation, ventro-suspension.

* Read before the Brooklyn Gynecological Society, January 4, 1901.

The utility of intra-pelvic shortening of the round ligaments has quite recently taken a position as a rational and efficient method in the correction of these deviations. It has limitations, and this fact will determine its applicability. If, after a retroverted or retroflexed uterus is relieved of adhesions and the barriers to normal replacement are, as far as practicable, removed, the question must then be determined as to the method to be followed in thus retaining it. If the round ligaments are of sufficient tensile strength to maintain the vagina properly, their shortening is clearly indicated as the simplest and best method at our command. The exact manner will depend much on the judgment or preference of the operator.

In Montgomery's new text-book on "Practical Gynecology" he describes the technique of three operations for intra-peritoneal shortening of the round ligaments as follows: "The operation may be performed, as Wiley has suggested, by doubling up from two to four inches of the ligament on each side and uniting it by sutures, so that the shortening of the ligament draws and holds forward the fundus." "Mann grasps the broad ligament about the junction of its middle and outer thirds and folds the ligaments in three parts, which are united by sutures, so that the ligament is well shortened on each side." "A. P. Dudley of New York performs an operation which he calls desmopyenesis. It is carried out as follows: After opening the abdomen, an assistant introduces two fingers into the vagina, pushes the uterus as high as possible in the pelvis, and it is thus brought through the abdominal incision; an oval denudation is made upon the anterior wall, taking care not to go too near the bladder; then each round ligament is brought up to the portion of the peritoneal covering of the inner side, denuded to correspond to that on the uterus, and the three denuded surfaces are united with catgut sutures."

In adjusting these sutures care must be taken to pass them sufficiently deep in the uterine tissue to secure against cutting out before union has occurred. The uterus when dropped forward is held in position of anteversion.

Whichever method is deemed best for any particular case, Dr. D. Tod Gilliam of Indianapolis, in a paper read before the American Association of Obstetricians and Gynecologists at Louisville in September last, advocated round ligament ventro-suspension of the uterus for retro-displaced uterus. He advocates this measure in that it will afford a natural support, with fair mobility and permanency, and will adapt itself to pregnancy and parturition. His method is a three-inch abdominal section, the breaking up of adhesions, bringing the round ligament to the opening, with the patient in the Trendelenburg post-

ure, and carry a thread about it one and a half inches from the uterus on both sides. He then exposes the rectus muscle near the lower end of the incision, and passes the margin of the incision and more than an inch above the pubes, and places the thread which surrounds the ligament into its jaws. The forceps is now withdrawn and both ligament and thread are brought up through the perforated wound in the abdomen, and while the ligament is held taut fastened by a to-and-fro catgut suture passed deeply through the ligament, including the tissues on either side. Whichever method is deemed best for any particular case may be adopted, or any other modification which seems more nearly to meet the indications when the round ligaments are much attenuated; or in the event of their absence, which occasionally happens, they cannot be made available for such purposes.

This manner of maintaining the uterus in position, which seems ideal and might be justly termed physiological, appears free of danger to the patient, which may be a fatal objection to fixation or suspension. If pregnancy follows, there should be with the enlargements of the uterus and adnexa such a corresponding lengthening of the round ligaments as will in no way interfere with the progress and termination of normal gestation, and herein lies its value. It would seem in physiological grounds that ventro-suspension would better meet the exigencies of gestation than ventro-fixation, though it would appear that in suspension there is greater risk of intestinal congestion or obstruction, than in ventro-fixation.

This, however, is not the principal risk which attends these measures, whether from ventro-fixation or ventro-suspension.

The danger arises from their becoming a barrier to normal and safe gestation. The recent experience of an eminent fellow of this Society, which is about to be made public, will serve to impress the skeptical with the danger attending such procedure, even though they may have escaped the grave complication which compromised the life of the unfortunate mother. The case was briefly as follows, for through the courtesy of the gentleman I was present at the operation. A woman, in her first pregnancy, had been operated on by one of the most distinguished American gynecologists for retro-deviation, and the intent was to suture the uterus to the abdominal wall so as to correct the displacement. It was found on completion of the period of gestation that Nature was unable to accomplish delivery from an anterior fixed position of the uterus, the fundus being close to the anterior abdominal wall. The cervix was fixed posteriorly high up by the tilting forward of the

uterine body, the cervical canal was four or five inches long, and the cervix refused to dilate on the appearance of labor. Cæsarian section was resorted to as the only possible mode of procedure, and twins removed. The twins survived; the mother succumbed to exhaustion. The operation revealed a dense adhesion about one inch square, holding the fundus close to the abdominal wall, which accounts for the "dystocia." The expectation of the operator that two or four stitches which united the fundus of the uterus to the anterior abdominal wall would stretch into a suspensory ligament was not realized, but instead there was an unexpected plastic exudate which became organized into adhesions so strong as to hold the uterus immovably forward. Just here is the element of uncertainty and danger. No operator can predict in advance if the uterus is stitched to the abdominal wall, how large or strong the resulting adhesions will become. If small, they will probably stretch into a suspensory ligament; if dense and large, they may result in innumerable adhesions, with a train of symptoms such as has been described. From the small number of accidents of this nature which have been recorded the inference is that the risk of ventro-suspension is relatively small, and if it could be demonstrated that such was the fact, it would go far towards relieving operators of the anxiety concerning such complications. On theoretical grounds it would appear that the danger of illness or the entanglement of the mesentery in such adhesions was a serious menace to the safety of the patient, but it must be admitted that in practice the gravity of procedure lacks confirmation. But notwithstanding the fact that cases have not been more frequently reported, I cannot escape the belief but that they have occurred. The question is raised by some of large experience whether an operator is justified in allowing his patient to take the risk of complications attending pregnancy after anterior suspension and fixation. There is some risk, no one will deny—how much or how little no one can predict with absolute certainty.

In a recent case coming under my observation of a young multipara suffering from chronic ovaritis on the left side, with prolapse of the organ, and extreme retroversion with adhesions, which was attended with pronounced neurasthenia. I removed the diseased, inflamed, and prolapsed ovary, stitched the uterus to the abdominal wall by silkworm-gut suture, which passed through the abdominal wall, and was fastened to a large, flat button at the lower angle of the abdominal incision, so that it could be removed, and ligated the right Fallopian tube, for the purpose of preventing further conception.

In deciding what is best to be done where in-

traperitoneal shortening of the round ligaments is insufficient or impracticable for correcting posterior deviations, associated with adhesions, making laparotomy necessary, the circumstances surrounding each case, the condition of the patient, and the desire for children in those married or those anticipating marriage, must be taken into account, and each case decided upon its merits. This statement, however, is not to be construed into a sentimental license for the prevention of conception per se. In case these posterior displacements demand operative interference, in those who have passed the child-bearing age, or those who will never enter wedlock, resort had better be had first to shortening of the round ligaments, if that will overcome the deviation, and if not, ventro-fixation or ventro-suspension. Due weight should be given to the risk of intestinal angulation or from obstruction to gestation arising from the undue size of the ligaments or adhesions which arise as a result of anterior fixation or suspension. The utility of these methods in relieving one of the most distressing ailments to which woman is subject is extremely satisfactory. The dragging pain, the backache, the mechanical obstacles to defecation, the direct pressure, and the reflex symptoms, few or many, which perturb the sympathetic nervous system, give place to healthy innervation, and returning health asserts its rightful sway.

To recapitulate: (a) Posterior deviations, with fixation from adhesions, are usually a serious menace to health and often a barrier to child-bearing; (b) that this condition of affairs can best be treated by laparotomy; (c) that after the adhesions have been severed the cure should be completed by maintaining the uterus in an anterior position: first, by intraperitoneal shortening of the round ligaments; second, if this is insufficient, resort should be had to anterior abdominal suspension or fixation; (d) that experience, while not settling all points associated with this subject, nevertheless has demonstrated that the efforts of maintaining the uterus in an anterior position either by ventro-suspension or ventro-fixation are, from the uncertainty of the degree and extent of the adhesion, not devoid of danger in the case of conception, which should be considered, and in many instances provided against; (e) that ligation or resection of the Fallopian tube is a more rational procedure than ovariectomy, for the prevention of conception, where justifiable, as it does not unsex the woman, and saves her from the premature menopause and its unpleasant consequences—a physiologic reason of much weight; and (f) the value of these methods of treatment of posterior deviations is amply demonstrated, and the necessity of their adoption should be more generally considered.

263 Hancock Street.

Irreducible Incarcerated Retroflexed Gravid Uterus.*

Dr. William A. Quinn of Henderson, Ky., read a paper on this subject, in which he stated that the pregnant uterus may become retroflexed by reason of great laxity of the uterine ligaments. It may become incarcerated by adhesions formed before conception takes place, or by the cervix pressing against the pubic arch, lifting the bladder out of the pelvis, elongating the urethra, and preventing perfect evacuation of the urine, which has a tendency to force the fundus down under the promontory of the sacrum. Softening of the lower segment, which takes place in the gravid uterus, lessens its self-support and its resistance, and robs it of its natural power to rise out of the pelvis and correct its position. With the persistence of the conditions which cause the retroflexion, and the rapidly increasing size of the uterus, it soon becomes incarcerated and cannot free itself. If the condition is recognized on or before the end of the third month, if adhesions and other complications are absent, often it is only necessary to thoroughly evacuate the bladder and lower bowel, and the uterus will free itself, or it may sometimes be necessary to place the patient in the knee-breast posture, and even to administer an anæsthetic, and it will require the employment of no unusual skill to easily and readily restore the organ to its normal position. Lusk, in his work on obstetrics, mentions sixteen cases by E. Martin, in four of which spontaneous reposition of the organ followed the evacuation of the bladder, and in eleven reposition was accomplished in the knee-elbow position. Lusk himself had never met with a case of irreducible, incarcerated gravid uterus.

A very prominent ætiologic factor in the causation of this condition is unrepaired former injuries to the pelvic floor. An incarcerated retroflexed gravid uterus, with the fundus snugly fitting down into the hollow of the sacrum under the promontory, meeting with no resistance from the pelvic floor, as pregnancy advances, goes on increasing uniformly in size until at about four and a half months it will be found to have so molded itself to the pelvis as to become irreducible.

The author quoted Hirst, who, in his work on obstetrics, gives an illustration from a frozen section of irreducible retroverted uterus of three and a half to four months, with death from rupture of the bladder. Hirst likewise mentions a collection of fifty-one fatal cases.

The following, in order of frequency, were the

* Abstract of paper read before the Southern Surgical and Gynecological Association, November 15, 1900.

causes of death: Uræmia and exhaustion, rupture of the bladder, septicæmia, peritonitis from inflammation of the bladder, pyæmia, rupture of the peritoneum and of the vagina, errors in treatment, and gangrene of the colon.

Dr. Quinn then cited an interesting case at considerable length, in which it became necessary to extirpate the uterus by the abdominal route. Six weeks from the time of the operation the patient was able to attend to her household duties.

On examining the specimen the uterus was found to contain a fetus, the arrest of development to which seemed to have occurred between the fifth and sixth months of fetal life.

At the time he did this operation he was not aware that abdominal section had ever been advised or practiced previously in cases of irreducible incarcerated retroflexed gravid uteri. Even the most recent works on obstetrics made no mention of it. In searching the literature, however, the author found that coeliotomy had been done in similar cases by seven different surgeons, and he said that to Dr. Mann of Buffalo belonged the credit of first doing coeliotomy for this obstetric complication.

♦ ♦

Popular Ignorance Respecting Medicine.

JOHN WILLIAMS, M. D.

"Christian science," with its claim to cure all diseases by ignoring them, flourishes most among the upper classes. Here it appears in gorgeous colors accompanied with the sound of trumpets, while at the other end of society it is found presenting a humble but obstinate front in the corner's court or before the police magistrate in the persons of its loyal devotees known as the "Peculiar People." Besides these immaterial means of curing diseases such as inflammation, paralysis, toothache, tuberculosis, and cancer, there are a countless number of undiscovered drugs, known only to their proprietors, which for good reasons are not made known to the public, each of which, according to their proprietors, and believers in these panaceas, have performed marvels in preventing and curing diseases, known and unknown, fatal and not fatal—indeed, it matters not of what nature, for all diseases, it is said, are cured by these undiscovered drugs. The astonishing fact is that any disease remains to afflict the human frame.

QUACK ADVERTISEMENTS.

You ask me where I obtain these extraordinary facts. I reply: Look at almost any newspaper, daily or weekly, religious or secular, and you will find all that I have stated. You will see accounts

of marvelous and impossible cures and statements of effects produced by drugs which everyone possessed of the most elementary knowledge of the laws of health and of the processes which take place in the living body knows to be entirely devoid of foundation. Nevertheless, these statements are published broadcast, day by day and week by week, in newspapers which profess to teach and lead the public and to form public opinion. These newspapers are the property of men who hold more or less influential positions and are respected in the country. They are edited, some by clergymen, some by ministers, and some by laymen.

The statements which I have referred to are sanctioned by silence, in speech, or in writing, by all concerned in the publication of these journals. They occasionally contain testimonials to the wonderful virtues of the advertised drug, and these emanate from all manner of men, some of whom are probably like the historical camel evolved in a garret, while others hold positions and make professions which would lead one to expect that they would not be guilty of attaching their names to, or be a party to publishing, anything for the truth of which they could not vouch.

Now and again a bard in a frenzy of inspiration pours fourth in rhythmic or alliterative measure the wondrous work of quackery and the miracles of ignorance.

When I find the religious newspapers besmeared with such advertisements as I have referred to, some of them not only false but foul and wicked, I cannot help feeling the blush of shame as I bear in mind under whose ægis they are published. The faithful, finding them in their weekly guide, accept them without question and act upon them as truths tested by the standard, sanctioned by their party oracles, and sealed with their approval.

How long will this continue? So long as the practice will pay the manufacturer and purveyor? Is it not possible to cause the purveyor at least to realize the character of the material to which he forms the conduit from the manufacturer to the purchaser? If this be not possible then the remedy must and will be found in the education which, if not now, will by and by be given in our schools. Let the elements of science, the laws of growth and decay, and the laws regulating the functions of the living body be taught in our schools and our young men and young women will themselves be able to estimate this mephitic rubbish at its proper value.

Cinchonæ co. has been used in cases of severe drink craving. Allow the patient to take 10 to 20 drops in a little chloroform water whenever he feels the craving coming on; this acts satisfactorily in some cases.

CURRENT MEDICAL LITERATURE.

Les Lois de l'Energetique dans le Regime du Diabete Sucre.

One of the latest of the excellent series of clinical monographs in elucidation of various questions of the day, which are being published by Masson & Co. of Paris, is Dr. Dufourt's on "The Laws of the Conservation of Energy in the Regimen of Saccharine Diabetes."

Amongst the many uncertainties and obscurities which surround the problem of diabetes he regards it as certainly proved that glycosuria is caused by an inability of the cells of the body to destroy sugar, and he assumes that they are compelled to consume albumen and fat in its place. Therefore, in the dietetic treatment of diabetes we have first to determine what is the precise amount of food, whether in the form of albumen, fat, or sugar, which the body requires. This he shows has been determined by Rübner as follows:

At rest.....	32.9	heat units.
With light work.....	34.9	"
With medium work.....	41	"
With hard work.....	48	"
for one kilogram (2 lbs.) of body weight.		

So that a diabetic performing only slight work and weighing one hundred and forty pounds requires daily the alimentary value of 2450 heat units (calories). The combustion value of the various alimentary principles has been established by the labors of Berthélot, Frankland, Rübner, and others, and the following are generally accepted:

One gram of albumen in being transformed into urea, water, and carbonic acid furnishes 4.1 heat units.

One gram of carbohydrates in being transformed into water and carbonic acid also furnishes 4.1 heat units.

One gram of fat affords 9.3 heat units.

Experience has shown that these substances are not absolutely interchangeable—that is to say, it is desirable to combine the three. Albumen is indispensable on account of the nitrogen which it alone can furnish, while experiments upon animals have shown that fat cannot altogether replace sugar. A diabetic must ingest sufficient albumen to supply the quantity of urea he is excreting, and, as is well known in this disease, the amount of urea is generally increased. According to Weintraud, a diabetic

requires from 1 to 1.50 gram of albumen per kilogram of body weight—that is to say, a man weighing one hundred and forty pounds would require from 21.2 to 4 oz. of albumen daily, which would be represented by from 121.2 to 20 oz. of lean meat.

The author gives some useful tables of the chemical composition of the principal articles of vegetable diet and of fruits. According to these tables potatoes, carrots, and turnips contain much less carbohydrates than the various farinaceous substances, or beans and lentils, while of fruits, peaches, apricots, and prunes occupy the lowest rank. He refers to the method recommended by Kraus, Jr., of preparing fruit for diabetics by repeated boiling in different waters, which must be thrown away on each occasion. The fruit is then sweetened with saccharine and flavored with a little cinnamon, and affords an addition to the diabetic diet which is much appreciated. Dr. Dufourt agrees with most modern writers in finding the various bread substitutes more or less unsatisfactory, and considers that it is best to allow a very small quantity of ordinary bread or to do without it altogether. He recommends the use of definitely limited quantities of potato. He does not approve of any of the modern sweetening agents which have been introduced, but we think he is unnecessarily strict in objecting on the score of possible gastric disturbance to the use of saccharine. This substitute has been employed very largely in England during the last fifteen years by many persons besides those who are diabetic, but we do not know that it is abused or that any ill-effects are traced to it.

With respect to mineral salts, the usual quantity taken in food is so much in excess of what is needed by the body that there is not usually any reason to consider the subject specially, but we may remind our readers of some observations by Grube on the administration of powdered egg shell as a popular remedy in diabetes, and upon his own observations of the benefit to nutrition which followed the administration of powdered phosphate and carbonate of lime in imitation of this substance. Cabbage, spinach, lettuce, and mushrooms Dr. Dufourt recommends on account of the small quantity of sugar which they contain, and he sanctions the use of vegetable marrows, melons, and cucumbers, but some melons contain far too much sugar to be safely used. He also recommends endive, salsify, and ground artichokes.

He says the sugar of tomatoes has been found to be almost entirely composed of *lævulose*, which is generally assimilated by diabetics. He speaks of the value of vegetables as a means of giving a suitable quantity of fat, but unfortunately all cooks do not understand how to add butter or oil in cooking them. He recommends four ounces of butter daily with an ounce of olive oil in salad, or this may be varied by fat bacon, brains, and yolks of egg. He is not a strong advocate for the use of alcohol, and in any case he thinks it better to give wine rather than spirits, red wine being preferable to white—that is to say, he would give his patients about a bottle of ordinary claret daily. He allows tea and coffee, but has some prejudice against mineral waters. He prefers ordinary water, which he quite properly says should be pure.

He condemns beer and cider, and is disposed to proscribe milk, but he allows that there has been a good deal of testimony in its favor, and he admits that it may suit some patients, and that it may be especially suitable to those with disease of the liver, heart, or kidneys, or with digestive troubles. He will not allow that strict diabetic diet ever caused coma, except by being so improperly calculated as not to supply a sufficient amount of nourishment. He recommends that the diet should be carefully arranged to suit each individual case, and that, where it is possible to do so, a certain amount of carbohydrates should be allowed. He thinks it advisable for such patients who are taking carbohydrates to submit from time to time to a course of strict diet for a fortnight, and he very properly insists all through upon the importance of the quantity of carbohydrates being strictly defined by weight.

**Ueber Wesen und
Ursache der Zuckerkrankheit.**

Dr. Leo is well known as an able contributor to the important subject of the physiology and chemistry of nutrition; he has, therefore, acquired the right to be heard respectfully when he has anything to say about the pathogenesis of diabetes. In his essay on the "Nature and Cause of Diabetes Mellitus," after passing in review recent additions to our knowledge, he concludes that true diabetes depends upon the inability of the tissues to destroy sugar, and that this inability is not explained by any hitherto observed or imagined changes in the organs or the blood; he has, therefore, thought it necessary to invent another hypothesis which he has endeavored to support by the series of experiments detailed in this work. This theory supposes the presence of an unknown poison in

the blood, differing from any of those hitherto recognized such as acetone, diacetic acid, oxybutyric acid, etc., which inhibits the oxidation of sugar by the tissues.

He appeals to Bremer's well-known blood reaction as evidence that there is something present not yet explained, for he considers that this reaction cannot be properly attributed to diminished alkalescence of the blood. He attempted some years ago to prove his theory by injecting blood or blood serum derived from diabetic patients into the bodies of dogs, but the amount of material he was able to deal with was necessarily very limited, and he was unable to obtain any satisfactory results. His recent experiments have been made with diabetic urine, which he regards as in all probability containing whatever poison is to be found in the blood. He has experimented with such urine taken from ten cases of diabetes of varying severity. The urine was sometimes injected unchanged, sometimes merely neutralized, sometimes after fermentation and neutralization, and sometimes concentrated. In eight out of ten cases he obtained positive results—that is to say, the urine passed by the dogs after these injections contained sugar. Control experiments made with normal urine gave generally a negative result, but glycosuria was observed twice. The author has not hitherto been able to isolate the poisonous substance, but he points out that it is something which is soluble in alcohol and water, not precipitated by oxalic acid nor destroyed by the temperature of boiling water. The second part of his work deals with the question of infection. Dr. Leo endeavored to determine whether the growth of micro-organisms gave rise to a poison which could produce glycosuria, and he found that in fluid in which ordinary beer yeast had grown such a poison exists which is neither alcohol nor succinic acid, and is not affected by neutralization. Attempts to isolate an organism in the blood of diabetics failed, as did attempts to produce glycosuria in dogs by diabetic fæces. The analogy of glycosuria with cystinuria has made him look for ptomaines in diabetic urine, but with negative results. So many poisons have been shown to be capable of producing glycosuria that hesitation is only right and proper before we regard Leo's experiments as affording any fresh point of departure for our study of diabetes.

**Some Questionable
Views on Diet.**

Dr. Emil Kleen, who is a Swedish physician practicing at Carlsbad, has had the courage and ability to write in English a book on "Diabetes

Mellitus and Glycosuria." While it is true that diabetes is most common among the educated classes, it is not unknown among the less cultivated classes, and the negro is not on a lower level of general culture than the Maltese shopkeepers among whom the disease is so prevalent. We do not know what ground the author has for saying that high altitude tends to increase the frequency of diabetes. We know no facts except those adduced by Purdy in support of this, and against them is to be reckoned the very important consideration that Maine and Vermont, which have high altitudes, are also busy manufacturing States, full of cities with just the sort of population in which diabetes would be likely to occur. We cannot agree with Dr. Kleen that small hemorrhages into the brain are commonly observed in diabetes or that it is probable that the small cysts mentioned by certain authors are the residual products of such hemorrhages, as it is generally held that cysts which are the result of hemorrhages and the absorption of hemorrhagic effusion betray their origin by hematoïdin staining. The cysts in question are absolutely and strikingly free from any traces of pigment. The tendency to hemorrhage upon which he lays stress is after all not such a very marked phenomenon in diabetes apart from gouty or other complications. As to the saliva of diabetics being often acid, if Dr. Kleen had made a practice of examining the saliva of adult persons, we think he would have found few whose saliva does not turn blue litmus paper slightly pink. Considering the indigestible articles of food upon which diabetic patients are so frequently fed it is surprising that so few suffer from symptoms of dyspepsia, but post-mortem it is the exception to find a diabetic stomach in a healthy state, this organ almost invariably showing some degree of dilatation with chronic catarrh of its mucosa. This does not agree with Dr. Kleen's view that gastro-intestinal derangements are rare in diabetes; but if we are to look to clinical symptoms alone he is right. There is no doubt that the failure to absorb fat becomes very pronounced in advanced diabetes.

The Prevention and Treatment of Obesity.

To laugh and grow fat is the aim of one-half of the world; the other half, haunted by the proverb that "*Un bon coq n'est jamais gras*," strives to become less fat. In an admirable book Dr. von Noorden shows us how by the regulation of diet and exercise we may preserve to our fellow-men the happy mean. Each species of animal has a fat the composition of which is

peculiar to itself. Each animal strives to maintain this normal composition and to burn rather than to store up the ingested fats which are foreign to it. The normal composition can be disturbed it is true, but only temporarily, by pressing a foreign fat into the diet. The feeding experiments of Chaniewski are quoted by the author as showing that 86.7 per cent. of the body fat deposited in young animals can be formed from the ingested carbohydrates. As to the theory of the formation of fat from proteid, von Noorden sums up in its favor. Everyone admits, he says, that glycogen is stored in the liver of an animal fed on a pure proteid diet, and everyone equally admits that fat can be formed from such a carbohydrate as glycogen.

The average normal diet, according to the author, should have the following values: Thirty calories per kilo of bodyweight for a man resting in bed; 35 to 40 calories for light work; 45 to 50 calories for hard work. The diet must contain at least 1.3 to 1.5 gram of proteid (weighed dry) per kilo of bodyweight. The store of N-holding compounds in the body of an adult cannot be sensibly increased by merely altering the nature or increasing the amount of ingested food. There must also be an increase in functional exercise to promote the formation of flesh. Excess of food runs to fat. The thin man requires more food than the fat man, not only because in him the skin surface, and, therefore, the loss of heat, is greater in proportion to the mass, but because the cells of his body, untrammelled by the deposition of fat, expend more energy. In estimating corpulency, the question of race is of importance. The Mecklenburg merchant is naturally of stouter habit than a Celt or a Latin. The muscular man can without harm become fatter than a man of feeble physique. For instance, the more muscular the heart the more can it stand the impediment of being loaded with fat. The record cases of corpulency quoted by von Noorden almost surpass belief. A child of fifteen months weighed fifty-seven pounds, a girl of ten years two hundred and forty pounds, and a man (recorded by Wadd) 1080 pounds. He points out how slight an increase in food or decrease in exercise may, in the course of the year, lead to the deposition of a large quantity of fat. Supposing that per diem two hundred calories worth of food were taken in excess of the needs, and the whole were changed into fat, this, in the whole year would add eleven kilos, to the body weight. The two hundred calories would be contained in 1.3 of a liter of milk, or 25 grams of butter, or 100 grams of fat meat, or 4-10 of a liter of beer; 50 grams of alcohol contained in a bottle of wine or 2 1-2 pints of beer

spares the combustion of 35 grams of fat or 85 grams of carbohydrate.

In discussing exercise von Noorden gives the following case: Suppose a man, weighing seventy kilos, lived in a flat of an elevation of fifteen meters, and went up to his dwelling four times daily. This would mean an expenditure of energy equaling 4200 kilogram-meters, and an expenditure of muscular energy equal to 1400 kilogram-meters, because only thirty per cent. of muscular energy is expended in the performance of work. If a man changed his flat to that on the ground floor and otherwise continued to eat and work exactly as before he might put on 1870 grams adipose tissue in a year (1 cal. = 425 kilogram-meters).

For von Noorden the cure of corpulency depends on two factors: (1) reduction of diet; (2) increase of exercise. Reducing the amount of liquid taken, just as separating the times of eating and drinking, reduces fat by lessening appetite. A reduction of water equal to 1 liter may lessen the total calories taken per diem by 100. In the quick cure the calories are lowered to 3-5 or even 2-5 of the normal amount. This treatment includes severe exercise, such as mountain-climbing. A man uses ten times as much oxygen in climbing one mile as in walking the same distance on the flat. The severe treatment is dangerous for weak patients, owing to the risk of heart failure. It is suitable for muscular, active men. In ordering the diet it must be borne in mind how greatly different modes of cooking influence the number of calories obtained from a given quantity of meat. For example: Two hundred grams veal when grilled contains 18.2 albumin, 5.1 fat = 122 cal.; when fried contains 18.2 grams albumin, 14.2 fat = 206 cal.; as a ragout contains 18.2 grams albumin, 20.1 fat = 261 cal. Von Noorden considers that the thyroid treatment for the cure of corpulency is neither good nor necessary. It produces loss of nitrogen, often glycosuria, nervous or heart symptoms, and is untrustworthy.

**The Universal Illusion
of Free Will
and Criminal Responsibility.**

M. A. Hamon has written a book—a bewildering kind of book—on "Free Will." He tells us that a man must be in an independent position, or of a very independent character, to give free expression to the views which he serves out as scientific truths. Apart from matter, M. Hamon cannot conceive force. He says that force is that quality of matter which causes its combinations to be infinitely variable, that

the conservation of matter is a principle which results from the observation of all phenomena, and that the hypothesis of free will is in absolute contradiction to the law of the conservation of matter and contradicts also the great principle of causality.

Dr. Johnson said, "We know that we possess free will, and there's an end of it." What is consciousness that it should stand in the way of M. Hamon's opinions? Consciousness may be wrong. All of us, he observes, are conscious that the sun goes from east to west, and this was long believed to be the case. Then we may be conscious of hallucinations. A man who sets out with an attack upon consciousness must stand the reply. If consciousness be deceptive, nothing is to be trusted. The truth is we are not conscious that the sun goes from east to west. All that we are conscious of is certain reflections and refractions of light in time and space from which we infer that the sun moves westward. But the data of consciousness are quite correct; it is the inference which was wrong. A belief that the sun moves is grounded upon the assumption that the earth stands still. When stopping at a railway station we sometimes think that our train is moving on looking at another train; but we correct our false inference by looking at some fixed bodies near. With the earth and the sun we have not this criterion. The case of hallucinations is more complex, but in general we easily succeed in distinguishing between subjective and objective modifications of consciousness.

For a speculator who decides dogmatically a question which has been the subject of debate to the acutest intellects, and which a great philosopher has declared to be beyond the powers of the human mind to solve, M. Hamon exhibits deplorably little analytical power. Having fortified himself by reading the books of many writers of the materialistic school, he rushes upon his conclusions without any misgiving.

Apparently he finds no difficulty in conceiving that thought is the product of the "vibrations" of matter, and that the cells of the brain at once receive, read, and register in the memory the changes in the arrangement of their particles. No one should be praised for doing right or blamed for doing wrong, for everyone is fatally impelled to do what he has done. Thus the sane are quite as irresponsible as the insane, though M. Hamon is zealous against the latter being treated as criminals. Not only does he think that "the mad or partially mad" should be treated as irresponsible, but he tells us that epileptics are considered by alienists as always irresponsible—a striking instance of

ignorance of practical medicine, for there are not a few patients subject to epileptic fits who do not appear to be affected in mind, and who lead good and orderly lives. The author admits that retaliation against offenses is a necessity for society, but he would substitute the term "social reactivity" for responsibility or penalty.

There is still remaining in the wide field of the world the practical difficulty of keeping wrongdoing in check without showing any moral indignation against the base and bad. How can we bring up children, or educate and govern societies, letting them know at the same time it is foolish either to praise or blame them for their conduct?

M. Hamon thinks that he has refuted Fénélon's arguments on this point. Our opinion is different. In conclusion we may quote the observation of Brunetière: "Were you sure that man is not free you ought not to say so, since the social polity and the entire ethics rest on free will as their only foundation."

♦ ♦

Olive Oil in Typhoid Fever.

OWEN F. PAGET, M. B., B. C. CANTAB.

May I bring before your readers a method of treatment first advocated by myself about two years ago? It consists in slowly administering every 12 or 24 hours an injection of olive oil per rectum. The quantity used for adults should be about a pint at a time, and should be retained in the bowel from 12 to 24 hours, if possible. If not returned in this time it may be brought away with an ordinary soap-and-water injection, a fresh dose of olive oil being administered two or three hours later. After a week or 10 days the daily use of the injections can be discontinued, and they are given only when the temperature rises or the bowels are confined. With diarrhea it is imperative to give olive oil, and those who try it will find it more efficient than opium or any other drug in bringing about a natural discharge of fæces. Occasional small doses of calomel, from one-tenth of a grain to half a grain, are useful if the oil is not sufficiently stimulating to make the bowels act. I use it now instead of giving olive oil by the mouth, which was found to be too nauseating for better-class patients.

My only medicine for typhoid fever, in addition to olive oil and the above-mentioned occasional doses of calomel, consists of carbonate of ammonia, glycerin, and decoction of cinchona given every three or four hours. Whether this preparation has any beneficial effect or not I am unable to say; it has the virtue of being probably

harmless, and without the glycerin was a favored preparation of Percival Pott. With oil injections the bismuth preparations are quite unnecessary. Patients treated in the above manner in my opinion cannot die; for careful observation has led me to believe that typhoid per se is a harmless fever, it is the accompanying sapræmia or ptomaine poisoning which produces the ill-effects. Under this line of treatment there are no sequelæ, tympanites, perforations, or heart failure. No cold baths are necessary. The most unskilled nursing is sufficient. Its only drawback occurs in private practice, where patients get well so easily that no credit accrues to the physician. Medical friends in Australia and Canada indorse my opinion as to its value.

I have heard that olive oil given per rectum has been found post-mortem in the stomach less than 24 hours after administration; if this is true it is of extreme interest, as showing that the beneficial effects of the oil extend above the ileo-cæcal valve. During a visit home last year a bacteriologist hinted that my patients were not suffering from true typhoid fever, but from some fever due to a closely allied bacillus. I can only state that Dr. W. T. Dermer examined a large series of cases here and obtained Widal's reaction in nearly all of them. Large bodies of men, as armies or gold-prospectors, who invade an undeveloped country, are invariably attacked with typhoid fever—witness West Australia, Klondyke, the Cuban campaign, and South Africa. My own hypothesis is that the bacillus present in virgin soil acquires virulence by passage through a series of hosts. An old prospector informed me that he knew of numbers of typhoid-stricken places in Australia which had completely cleared themselves in a few years without any attempt at sanitation. Do the inhabitants and their children acquire immunity or does the bacillus lose its virulence? People alone in the bush, living on apparently virgin soil, can develop typhoid fever. In the case of my own child, aged two and a half years, who nearly died from enteritis (not typhoidal) accompanied by a recrudescence of malaria, and who, on recovering from the acute stage, daily passed casts of the intestine, the condition was completely cured in from two to three weeks by injections of olive oil, protargol and other remedies having been used in vain.

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Treatment of Gouty Eczema.

GILBERT JOHN KING MARTYN, M. D.,
Bath.

As regards the real values of internal remedies in gouty eczema, the text-book statement on this point usually is that those drugs which are used

as gout specifies, such as colchicum, lithia, or piperazin, should be given. Personally, I have never seen them have the slightest influence in controlling or curing the eczema.

Of real value are those drugs which benefit dyspepsia and increase the alkalinity of the blood, such as bismuth, the alkalies, and the bromides. Antimony will at times relieve the intense itching, but when the patient is kept awake and tortured by the eczema, when the temptation to scratch or rub is too strong to be resisted, and when there is no strong contraindication, morphine should be injected hypodermically. By so doing we secure a peaceful night, and place a moist acute eczema under the most favorable conditions for healing. Arsenic is a difficult weapon to handle. Roughly speaking, the less irritation there is, and the more the eczema inclines to the dry and scaly type, the more will arsenic be found of value.

The daily use of some mineral aperient water, taken in the morning when fasting, should never be omitted. More important than the internal medication is the local treatment of the eczema.

For the very acute moist inflammatory type soothing lotions containing lead and opium should be constantly applied. As soon as the irritation begins to disappear and the exudation lessen, I always substitute a dusting powder of carbonate of magnesia and Fuller's earth.

For the dry, irritable type, I find nothing excels the old-fashioned tar in the form of the liquor carbonis detergens, and it should be used in a very diluted form as an ointment, 10 minims of the liquor to an ounce of lanolin. The great area of the body which eczema so often occupies renders the employment of lotions and ointments difficult, and it is in these cases that the employment of baths is so valuable.

The time-honored tradition that all eczema is to be kept religiously from water is still fostered by many patients, and it is one of the hardest points to decide whether an eczema will be made better or worse by immersion in a bath. My experience teaches me that the amount of irritation is not the criterion of this point. Intensely itching eczema is frequently soothed and ultimately healed by such treatment. But when there is much redness or inflammation or exudation, baths only serve to make matters worse. A lime sulphated water is admirably adapted for cases of dry, irritating, scaly eczema. Too much care cannot be taken over the detail of the bath. This should never be given at a temperature exceeding 98°, and the usual hot pack after the bath must be omitted. The whole body must be carefully dried and powdered after the bath, and the patient must go straight home after thoroughly cooling, so as to avoid any chill to the surface. In the more obdurate chronic types I order the

addition to the mineral water of sulphur water prepared by boiling sulphur and slaked lime.

This is by far the best preparation of sulphur to use, as it closely resembles the natural sulphur springs. It is easily made, and will keep for a considerable time if it be kept cool and the air excluded.

I call an eczema a gouty eczema when it is associated with a certain combination of symptoms which in my experience are, briefly, an extreme irritability of mucous membrane and skin. The gastric mucous membrane will pour out an excess of acid on the slightest provocation, as a strawberry; the skin and the other mucous passages show the same susceptibility. Take, for example, a group of diseases which I have termed the gouty triad—that is, asthma, hay fever, and eczema. How often these occur in the same patient, alternating with one another. The physiologists are as far as ever in telling us the rôle of uric acid in gout. In my opinion it is a by-product and an unimportant one in gout. Its presence or absence in the urine is no criterion in gout. Far more important in the diagnosis of that group of symptoms known as gout are the other numerous manifestations of the inherent irritability and inadequacy of the various secretive and excretive organs.

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The Treatment of Chronic Diseases.

BURTON G. THOMAS, M. D., M. R. C. S.,
New York,

Consulting Surgeon to the Ridgfield Sanitarium.

In the treatment of chronic diseases, and particularly of those complicated with digestive disturbances,—and I may remark here, in passing, that chronic disease in nearly every case is, to a greater or less degree, originated and maintained by the impairment of the nutritive function, imperfect metabolic exchange,—the selection of a suitable diet, providing a food that is nutritious and at the same time readily assimilable, is of equally great importance as the strictly medicinal treatment.

The reason for this is clearly apparent when we remember that the most recent physiological researches have demonstrated that all of the grave chronic diseases—tuberculosis, diabetes, albuminuria, as well as the more serious nervous lesions—have their origin in a perversion of nutrition, metabolic derangement—in other words, in the disturbance of the equilibrium between organic waste and repair; this metabolic derangement producing insufficient nutritive supply which reacts in turn in increasing the imperfect metabolism, and thus establishing

a vicious circle which induces and maintains a chronic diseased condition.

Whether the failure of nutrition or the disturbance of the nerve centers from other causes be the primary source of the disease is of minor importance, since the fact remains that until the vicious circle is broken and nutrition restored the cure of the diseased condition and the restoration of the integrity of the nerve centers is well-nigh impossible.

For a considerable time I have used in the treatment of this class of diseases tropon, one of the newer preparations which modern chemistry has given us, an artificial food, with most excellent results. This preparation, which I have used in a number of cases, consists of nearly pure albumen, derived from animal and vegetable sources, and is quite easily digested by the gastric and pancreatic juices, affording the maximum of nourishment with the least tax upon the organs of digestion.

The excellent results obtained with tropon are well shown in the following cases:

Case I.—Mrs. B., aged thirty-six, highly nervous temperament. Has suffered all her life from imperfect digestion. Subject also to severe neuralgic pains about the stomach and chest. As a rule, after a longer or shorter interval of comparative health, she would become extremely nervous, lose her appetite, be unable to sleep, with sharp neuralgic pains about the stomach and chest, all growing gradually worse until she would be confined to her bed; the attack lasting for three or four weeks. The last attack, in October, the second under my care, began as usual and continued until the neuralgic pains became extremely severe before I was called.

She was immediately placed upon the same treatment as in the preceding attack; a powder of charcoal, in a cup of hot water before breakfast, tincture of nux vomica and cinchona through the day. In addition to this she was ordered to take a teaspoonful of tropon a day.

Instead of running the usual course of three or four weeks the disease was cut short almost at once, and she had regained her ordinary health in less than a week.

Case II.—Neurasthenia. Mrs. S., forty-eight years old, nervous temperament. Has suffered with nervous prostration, due to anæmic condition of the blood from defective assimilation and imperfect digestion, for several years. In addition to tonic treatment with arseniate of strychnine, arseniate of quinine, etc., she received tropon with iron, a teaspoonful daily. Marked improvement in her general condition followed within a short time. She gained in strength, and particularly in will-force and in control of her nerves. A noticeable re-

sult obtained in this case was in the action of the bowels. For seven or eight years there was a relaxed condition throughout the intestinal tract. The food was imperfectly digested, and she would have every day five or six loose, liquid passages. Within a few days after beginning with the tropon her digestion improved, and instead of the five or six liquid stools she has had but one, formed, normal stool a day. The effect upon the mental condition was equally gratifying, her mind clearing up, and she has now become hopeful of an ultimate cure.

Case III.—Mrs. F., subject from early life to severe headaches, occurring at irregular intervals and lasting for several days. During the continuation of the headache the stomach is greatly disturbed with nausea, vomiting, and inability to take food. After the headache there are prostration and debility from want of food. In recent attacks, in addition to the usual treatment, tropon was given, a teaspoonful a day in malted milk. The headaches thus treated have not been followed by the usual weakness, and the headaches do not recur as frequently as formerly.

Analysis of tropon shows it to be composed of:

Water	9.77
Albumen	88.76
Substances soluble in ether.....	0.34
Mineral	1.13

It consists, therefore, of almost pure albumen, and theoretically is an ideal food in all debilitated and anæmic conditions, highly nutritious, readily digestible, easily assimilable, and free of waste or inert material. Clinical experience and practical use have demonstrated the correctness of the theoretical combination and the very great value of tropon in all cases where a highly nutritious, easily assimilable food is needed.

It is a light-brown powder, of a not unpleasant taste and of a sandy consistency. As already stated it is derived from animal and vegetable sources. In the dry state it is not perishable, is not hygroscopic, and is not soluble in water, although it is readily acted upon by the gastric and intestinal fluids. It possesses the advantages of unlimited durability, tastelessness, small volume, and easy digestibility, and is low in price. A feature of pure tropon I must mention is its insolubility in water, so that it does not readily mix with liquid food, and a little care is required in preparing the food for patients affected with anorexia or gastric disturbance. This is readily overcome, however, by giving the tropon when the administration in powder form is necessary in capsules or wafers. This does not refer to the iron tropon, which is soluble in all

liquids, and being very palatable is relished by most patients. Almost every patient can take the pure tropon, however, in milk or in malted milk, and most invalids take it without difficulty with their usual diet. As a teaspoonful of the powder is equal to four ounces of pure meat albumen its very great food value is clearly apparent.

For the tedious sequelæ of the grip, which so often baffle the physician, and for the quick restoration of the vitality and muscular power, the loss of which is one of the most distressing signs of this scourge, the iron tropon is especially indicated, as it contains all the necessary ingredients for the relief and for the restoration of the constituents lost during the process of the disease. It cannot be too highly recommended for this purpose.

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Complete Transposition of Viscera.

Lenormant and Durand-Viel (Bull. et Mém. de la Soc. Anat. de Paris) have dissected a perfect case of "situs mutatus," or complete transposition of the viscera. The patient was a woman, aged twenty-two, who died of subacute phthisis. It is not stated that the anomaly was detected before death. There was no defect of development in any of the viscera. The right lung had three lobes, the left two, the apex of the heart pointed to the right, the arch of the aorta passed backwards from left to right, the right recurrent laryngeal passed under and turned upwards behind it, whilst the corresponding nerve on the right side turned up under the subclavian artery. The innominate artery gave off the left subclavian and common carotid, the right subclavian and common carotid each arose direct from the arch. The azygos veins were reversed in a similar manner, and it was the right vagus that ran along the front of the esophagus. The stomach and liver were also consistently reversed, the spleen lay above the right loin, the head of the pancreas lay to the left, the tail to the right. The vena cava lay to the left of the aorta, the right ovarian vein ran into the renal vein, the left into the vena cava.

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Surgical Emphysema of the Eyelids.

CHARLES LEO BIRMINGHAM, M. D. R. U. I.

On October 13, 1900, a patient of mine who was walking along a public road and carrying an open umbrella for protection from the rain had his umbrella suddenly blown against his face. One of the ends of a rib of the umbrella struck the right eye close to the caruncula lacrymalis. This caused a slight wound which did not bleed.

There was no pain and my patient continued his walk. About three hours later he had returned to his dwelling and was sitting in an armchair removing his boots when he paused to blow his nose. Immediately his eye was closed with an inflated swelling of both the lids. I was summoned in great haste, and arrived about 15 minutes after the onset of the swelling, when I found that the enlargement of the lids was so great that not even the eyelashes could be seen. Gentle pressure on the lids gave rise to a "crackling" sensation. On hearing of the injury I at once diagnosed surgical emphysema of the eyelids. Without delay I began to apply gentle, slow, continuous pressure, using pads of lint soaked in boric acid solution beneath my finger ends. Within an hour I had the eyelids emptied of air. I left a pad of lint on the eye firmly fixed with a bandage. Recovery was subsequently uninterrupted and the patient is now able to blow his nose again. There was slight epistaxis on the third day after the injury. My explanation of the recurrence of the emphysema is that the lacrymal apparatus was ruptured at the junction of the canaliculi and the sac. None of the books on surgery which I have been able to consult records any case of injury such as I have described.

♦ ♦

Methylene Blue as an Analgesic.

Klemperer (quoted in Méd. Mod., June 27) has recently published his results obtained by the employment of methylene blue as an analgesic in twenty-seven cases of sciatica. In eight cases it failed entirely, in six cases the pains marvelously disappeared in five days, in the remaining thirteen the sciatica resisted the treatment for several weeks, but the pains were less frequent and the patients were enabled to sleep at night. Three to six capsules containing 0.45 gram (about 7 grs.) were given daily. Slight gastric disturbances occurred, but they involved no serious inconvenience, and any pain during micturition was easily annulled by adding a little nutmeg to each dose. The writer has found the medicament very useful in tabes, neuralgia, and myalgia in diminishing the intensity of the pains. In these conditions it is best to commence with 0.25 gram (4 grs.) twice a day, and very gradually increase the dose up to one gram (15 1-2 grs.) or more. The substance must be absolutely pure, otherwise gastric, toxic, and diarrhetic troubles will follow. It should be administered in well-made cachets, so as to avoid any coloration of the oral cavity. The patient should be warned of the urinary change of color, and that some slight vesical spasm and dysuria may occur. The action of the blue causes at first a numbness,

passing gradually into analgesia; its action is rapid, but of not long duration. Hence it is necessary to continue the medication whilst any pain is felt. Local effects can also be obtained, but the disadvantage of its coloring power has not yet been overcome. It has been proposed also to use the blue in subcutaneous injections, but at present there have been no experiences published. It is claimed that methylene blue in excessive doses does not cause the depression, etc., of increased amounts of ordinary analgesics, and is worthy of extended use.

♦ ♦

Bromide Sleep in a Case of Mania.

PHILIP M. RAGG, M. B., C. M.,
Kingston, Jamaica.

I lately attended in private practice a case of mania in which resort to the bromide treatment gave excellent results.

The patient, a young man, had been for eight hours in a state of alternating exaltation and depression when I was first summoned, the exciting cause being domestic and pecuniary worries of no great magnitude. He had taken at one dose forty two-grain quinine pills, with the avowed intention of committing suicide. Profuse sweating, headache, nausea, and prostration, with a temporary mitral systolic murmur resulted; and, though in a state of great mental excitation, his physical discomfort rendered him at first very amenable to treatment. The first four days 20 grs. of sulphonal with 30 grs. of ammonium bromide were administered every twelve hours. After each dose he slept for some hours (as much as eight on the second night), but with incessant movements of the limbs and changes of position. He ate heartily, but in the intervals the mental exaltation increased, and he suffered from restlessness and delusions that made him difficult to manage. Thus on the third day, after a four-and-a-half hours' sleep, during the absence of the one available trained nurse, he gave his watchers the slip, and I arrived just in time to intercept him in the street, one hundred yards from home, in a state of great excitement, staggering like a drunken man, singing at the top of his voice, and accosting passers-by.

On the fourth evening he attacked me furiously under the delusion that I was robbing him of his wife, to whom he is much devoted, when I sent her exhausted to rest in an adjoining room. On the fifth day, being anxious to keep him, if possible, out of the asylum, and after consultation with the medical superintendent of the institution, I determined to try the effect of the bromide treatment. In order to allow the effects of the sulphonal (last administered at 1 a. m.) to pass

off, the new treatment was not commenced till 4 p. m., when he was again in a state of great exaltation, talking incessantly, with bursts of maniacal laughter. Potassium bromide in 2-dram doses was then given at 4, 6, and 8 p. m., followed in each case by a tumbler of milk. At 9.15 p. m. he was apparently in a deep sleep, but as preparations were being quietly made for his wife's return to the next room for the night, he got up in bed, and with many invectives threatened to "do for me." He fought furiously for about thirty seconds, and then fell back exhausted. On assurances being given that she should remain in the room he became tractable, but a quarter of an hour later tried to follow me downstairs to "square me in the open." At 10 p. m. 3 drams of potassium bromide were given, and after an hour's incessant talking, in which he was profane and witty by turns, and extravagantly lauded to his wife's personal charms, he got eight hours' sleep.

On the sixth day the potassium bromide was given, in 2-dram doses, at 8 and 10 a. m. and 12, 2, and 4 p. m., followed in each case by a tumbler of milk, giving a total of 19 drams of bromide in the twenty-four hours. The early administration was due to his refusing to remain in bed and being intractable in the morning. From 10 a. m. onwards he slept soundly, and required some rousing for the two-hourly draughts. There was slight difficulty in swallowing, but he drank from a tumbler and assisted in holding it. He got up without suggestion during the day to obey the calls of nature. At 6 and 8 p. m., after being roused to take milk, he became restless and loquacious.

On the seventh day, having had fairly deep sleep through the night, at 5.30 a. m. he got out of bed to pass water, then fell into deeper sleep, which continued throughout the day with little muscular movement. He lay with eyes half open and gazed, mouth wide open, breathing somewhat stertorously. He was roused every two hours to take milk; he recognized those who gave it, always looked across to his wife, smiled, spoke affectionately in a thick voice, and went off at once to sleep. His tongue was covered with a thick white fur, and his temperature was normal throughout the progress of the case. At 4 p. m., when his wife was speaking to me at the door, though apparently in profound sleep, he roused himself—suspicious, as always when she moved—swore violently at me for my "intention of removing her," struggled hard for a few moments, and, quickly exhausted, went off to sleep again.

During the whole of the eighth day he slept profoundly, even more so than on the seventh. His face was pallid and somewhat leaden in hue; he took milk as before, but with more difficulty in swallowing, so that on three occasions he was fed

with a spoon. He got out of bed once to follow his wife when she left the room; however deep his sleep, he seemed to wake instinctively if she left him.

On the ninth day he had deep but more natural sleep.

On the tenth day, having slept well all night, he was easily roused, and took a light breakfast with relish, but he had difficulty in swallowing. He slept the greater part of the day and was always drowsy. There was no extravagant behavior whatever, except insisting on kissing the nurse, and he allowed his wife to leave the room at intervals without suspicion or demur.

On the eleventh day, after a good night, he was rational and very amenable to treatment. He was extremely weak, but walked with assistance round the room, when he was content to go back to bed for the rest of the day, feeling "tired." He slept most of the day.

On the twelfth day he left the bedroom for the first time, and shaved himself well. His tongue was still very foul. His mental state had returned practically to his normal, which is that of a restless, excitable, and rather self-willed individual. From this time onward there has been a steady return of physical strength, and he has been rational in his behavior, but easily affected to tears for the first few days by a sense of his inability to work, by acts of kindness and occasionally when not allowed to act on his own judgment.

In the treatment of this case the drug was not pushed to the extent advocated by Dr. Neil Macleod, as after a twenty-four hours' cessation I judged further administration unnecessary. Still it seems remarkable in view of his reports that the patient, after the heroic doses given, responded throughout without suggestion to the calls of nature, and was able so obviously to keep jealous watch, waking or sleeping, over the movements of his wife. The statement that "the full effect of the drug is not manifest for at least twenty-four hours after the last dose" is well borne out. With regard to this method being "a new departure in the treatment of acute mania," I would refer to Clouston, when he says: "I have used the bromide alone in acute mania extensively and experimentally. In small doses it seems to have no effect. In very large and continuous doses, say a dram every three hours, continued for many days, it will cause bromism and quiet the patient; but when its influence is over he becomes as bad as ever. I have never seen any medicine where the maniacal excitement and the physiological brain torpor of the drug seemed so visibly to fight for the mastery." It would appear from this that the same quantity of the drug per diem is more potent when given in larger doses at shorter intervals.

Liquor Thyroidei In Hæmophilia.

C. ROYDS JONES, M. D.,

Bunbury.

In 1898 I reported a case of hæmophilia in a girl of eight years of age who had had from infancy very extensive hemorrhages every two or three weeks from the mucous membranes of the digestive tract. Iron, cod-liver oil, sulphuric acid, calcium, and arsenic all failed to have any effect, and I had ceased trying any drug when my attention was drawn to the fact that Delace had given thyroid in one case with success. I tried it in my case, giving 4 minims of liquor thyroidei three times a day, beginning on May 1, 1900; there was a slight hemorrhage a fortnight later, but none since. She continued taking the drug for six weeks; since then there has been no return of the bleeding, and the child looks far healthier and stronger than she ever did before. There seems little doubt that this good result is due to the thyroid treatment.

♦ ♦

*Advantages of the Spray in Pseudo-Membranes of the Pharynx.**

* Abstract from the New England Med. Mo.,

D. C. BROWN, M. D.,

Danbury, Conn.

In my experience for attack on the pseudo-membrane in diphtheria the spray is better than any other means. Irrigation fails to give the penetrating power necessary to get to the middle layer of the pseudo-membrane. It and gargles are good for cleansing, but I fail to see the reason for the oblivion to which modern teaching has consigned the spray. I admit that harm may be done with it, and that the child fights against it; but the same objections hold good against irrigation, and the young cannot gargle. I avoid spraying the uvula unless covered with a pseudo-membrane, and in fact avoid any healthy membrane with the direct force of the spray, for I aim to get force enough to see the tissue splay out with the spray.

Personally, I have two favorite solutions which I rely upon to be used as sprays in accordance with the individual case. The first is hydrozone, and I direct that the nurse put two teaspoonfuls with three to eight teaspoonfuls of water and use at first every half hour or hour. I use this especially in all denser membranes, that the hydrozone may break up and disinfect the middle layers of the pseudo-membrane. It makes a way for other antiseptics which may be subsequently used.

The second spray is a solution of formaldehyde, directed to be used as follows:

R Sol. formaldehyde, $\frac{1}{4}\%$, ...	30-60.	$\frac{3}{4}$ j- $\frac{3}{4}$ ij
Kal. chlor., ...	8.	$\frac{3}{4}$ ij
Acid. boric, ...	4.	$\frac{3}{4}$ j
Glycerine, ...	15.	$\frac{3}{4}$ ss
Aq., ad., ...	120.	$\frac{3}{4}$ iv
M. Sig. Use in spray after hydrozone.		

This I make the standby and vary the strength according to the conditions, and continue with it when the pseudo-membrane has become so thin that I do not care to continue with the hydrozone. Remembering the middle layers of the pseudo-membrane and the depths of the crypts, I shoot hard and quick and resort to the spray early, and very often do not have to use the antitoxin.

♦ ♦

Apomorphine as a Hypnotic.

E. W. ADAMS, M. D.,
Sheffield.

Some little while ago I was called to see a middle-aged woman who, by her excitable and restless behavior (due to alcohol), was causing no little inconvenience to those in her immediate neighborhood. As a first step I deemed it would be advantageous if she and some of her unabsorbed alcohol could be made to part company. To this end I decided to administer apomorphine, declining the siphon from, I fear, not altogether disinterested motives. A hypodermic injection containing gr. 1-15 of this drug was accordingly given. The expected, however, did not occur. In about twenty minutes she was quietly sleeping, much to the relief of her friends and the surprise of her medical attendant.

The dose, it will be noticed, though smaller than usual, is yet double that sometimes used, and its hypnotic effect in this case is rendered the more curious by reason of the fact that so far from aiding the ineffectual retching which was present, this latter was quelled by its exhibition.

♦ ♦

Treatment of Threadworms.

J. E. P. writes: "I have never failed to cure threadworms in children by passing a small portion of unguentum hydrag. mitius into the rectum every night for two or three nights, followed by a small dose of castor oil next morning."

Drs. Scudder and Cotton advocate in general the use of splints as a dressing in preference to plaster-of-paris.

Book Reviews.

The Treatment of Fractures. By W. L. Estes, A. M., M. D., Director and Physician and Surgeon-in-Chief of St. Luke's Hospital, South Bethlehem, Pa. 216 pages. International Journal of Surgery Co., New York. 1900.

This book, in common with many others of late, is devoted solely to treatment. The author states that much of the text is the result of fifteen years' experience along this special line of work, and, as a result, there are many novel and helpful suggestions. Each of the individual fractures is discussed, and then at the close of the work is an especially good chapter on compound and complicated fractures. The book is rather small and unpretentious, but many of the illustrations—reproduced from photographs and skiagraphs—are excellent.

Students' Edition, A Practical Treatise of Materia Medica and Therapeutics, with special reference to the Clinical Application of Drugs. By John V. Shoemaker, M. D., LL. D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia; Physician to the Medico-Chirurgical Hospital; Member of the American Medical Association, of the Pennsylvania and Minnesota State Medical Societies, the American Academy of Medicine, the British Medical Association; Fellow of the Medical Society of London, etc., etc. Fifth Edition. Thoroughly Revised. 6 1-4 x 9 1-2 inches. Pages vii., 770. Extra cloth, \$4.00 net; sheep, \$4.75 net. F. A. Davis Co., Publishers, Philadelphia.

In this, the fifth edition, the author has seen fit to divide the work into two separate issues, the first, and present, one to be called the Students' Edition, and the second, soon to appear, to be known as the Physicians' Edition. In the Students' Edition only such preparations are dealt with—with some of their modifications—as are recognized in the United States and British Pharmacopœias. Before the author begins the consideration of the separate remedies he discusses some of the general considerations relating to the subject in hand, one especially good topic being "Prescription-writing and Formulæ."

The drugs are taken up alphabetically, each one, as the writer puts it, "being treated from three different points of view"—the pharmaceutical, the physiologic, and the therapeutic.

The work is so complete that it might almost

be called exhaustive, still it is concise and clear and the style is readable. As is proper, the metric system is used throughout, though the equivalents in the English system are always given. The student will thoroughly appreciate this as a text-book, and so undoubtedly will the professors who are called upon to teach this branch of medical science, for it is brought up to the moment, and written by an authority whom but few or none may question. The author is to be heartily congratulated on his most excellent work. The binding and the typography are all that could be wished for, and the indices, general and clinical, are very complete—in happy contrast to many medical books. We anticipate, with interest, the Physicians' Edition of Dr. Shoemaker's work.

Progressive Medicine, Vol. III., 1900. A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 408 pages, with illustrations. Per annum, in four cloth-bound volumes, \$10.00. Lea Brothers & Co., Philadelphia and New York.

This volume deals with the recent advances made in four branches of medicine and surgery. The first and most important section is by Dr. William Ewart of London, and deals exhaustively with the Diseases of the Thorax and its Viscera. The second part, Diseases of the Skin, is signed by Dr. Stelwagon; the third, on Diseases of the Nervous System, is by Dr. Spiller, and the fourth, by Dr. Norris, treats of the subject of Obstetrics. Each division is complete in itself, and is invaluable for the purpose of bringing the physician's knowledge of the subject thoroughly up to date. The subject matter of the book is too extensive to be reviewed more in detail, but the names of the gentlemen who have contributed are in themselves a sufficient guarantee of the worth of the volume.

Progressive Medicine, Vol. IV., 1900.

This volume, the fourth in this series, is a trifle larger than the preceding one, and its contents are fully up to the high standard set by the editor of the work. The first article, on Diseases of the Stomach and Allied Organs, by Einhorn, deals especially with the treatment of stomatic diseases, though there is a most interesting consideration of "Floating Liver." Genito-Urinary Diseases and Syphilis is dealt with by Dr. Belfield, Physiology by Dr. Brubaker, and Hygiene by Dr. Baker; this last article referring in a practical

manner to toxins and their relation to disease. Dr. Bradford of London discusses Diseases of the Kidney, while Dr. Bloodgood has an exhaustive article on Fractures, Dislocations, Amputations, Surgery of the Extremities, and Orthopedics. Most of the illustrations are found in this section. The last hundred pages are devoted to a Therapeutic Referendum, edited by Dr. Thornton, and in it are found excellent accounts of the newer remedies, and the new uses of the old ones as well. The closing remarks in the preceding review apply with equal force to this volume.

Topics of the Hour.

Recently a new agent has been brought forward to assist in relieving the most obstinate cases of *traumatic joints*, namely, the hot-air treatment. It is practically baking the limb in a hot-air oven in which the temperature is carried approximately to 300° F.

From the careful observations and experiments in the use of hot air reported by Frazier in 1897, we learn that when a limb has been subjected to a temperature of 300° F. for an hour, a diffuse hyperæmia of the integument may be plainly seen, there will be a temporary numbness of the part, and, if there be not complete ankylosis, less pain and more freedom in the movements of the joint. He believes that all the benefits are the results, not of any constitutional effects, but of purely local influences. These he finds chiefly in a locally stimulated circulation, which produces a temporary oedema and permits of a certain amount of mechanical stretching, at the same time carrying away and flushing out the fluid that lies stagnant in the tissues. In other words, the hot-air treatment accomplishes, perhaps, a little easier and more thoroughly because the heat is greater, just what has been attempted by the more old-fashioned method of the hot pack or the steaming in hot, moist flannels. It prepares the joint and puts it in a most favorable condition for massage and active exercises. To this extent it is a useful adjunct to the methods already described, but is of little avail without them.

I desire to express my belief:

(1) That all injuries to joints accompanied by loss of function are always attended by more or less laceration of the tissues in or about the joint.

(2) That the delays in the restoration of function are due in most instances not to any complicating diathesis, but to the changes incident

to the repair of these lacerations and their effects.

(3) That such delays are best avoided by an early resort to massage and active or passive motions, and are favored by too long a continuance of rest and fixation.

(4) When such delays have occurred they are best overcome by more vigorous and persistent manipulation, supplemented by the application of heat or such other agents as may best stimulate the local circulation and favor the elasticity of the tissues.—Homer Gage, M. D., Worcester, Mass.

I have taken much interest in the subject of *irritable breasts*, and have had many opportunities of following patients so afflicted for considerable periods of time. To begin at the beginning of the subject, these conditions of the breast occurred notably at two periods of life—in adolescence and also at the time of the menopause. These breasts may be occupied by several more or less distinct lumps or may contain but one such swelling. This condition often entirely disappears under treatment, and the treatment recommended is the internal administration of iodide of potash, combined with bromide of potash. The irritation of the breast seems to have very close connection with the condition of the pelvic organs. It is very common to find in these cases that there is some disturbance of the uterus, usually with irregularities of menstruation. Not uncommonly the condition of the breast is very much aggravated, with increase of swelling and of pain at the time of or just before menstruation, and this condition of pain and swelling (tumefaction) is relieved by the completion of menstruation. The pathological condition of these breasts in their early stages is difficult to demonstrate, because it is not a fatal disease, and it is a disease which we rarely operate for. If medicine is given, and the tumor disappears entirely, operation is not advisable. When, however, the swelling persists, or reappears, and an operation is finally done, the condition found is usually a diffuse fibrous condition of the greater part of the breast, which by its pressure upon the ducts gives rise to the formation of retention cysts. These cysts are sometimes single good-sized cavities, with little fibrous tissue about them; but usually they are small, and are scattered pretty thickly through the fibrous tissue of which the breast is largely made up. The changes in the size of the swellings, and the rapidity of these changes, especially at the time of menstruation, made it appear probable that a tumefaction, that is, an increased determination of blood to the parts, is largely responsible for the increase of size which causes

a tumor. It is plain, however, that when the condition persists for a considerable time, new cells are thrown out which become organized into the fibrous tissues described.—Arthur T. Cabot, M. D., Boston, Mass.

I will narrate a plan adopted during many years in a very large majority of my cases of *chorea in children*. When they come in, unless there is very obvious cardiac mischief, my custom is to put the patients upon a course of *saccharum lactis*, and see that they get it regularly. This last point is very important. The mental effect upon children of such a course of treatment is distinctly beneficial. The reason for commencing treatment in this way is that so many of the cases seen in hospital practice were of the kind known as emotional chorea, or chorea from overpressure. A great deal is heard from parents of the patients having had a fright; but when pressed for definite particulars the story of the fright is frequently a very lame one. But whatever the origin of chorea, once the pernicious habit is formed—for I am persuaded it is a habit—there is in the domestic atmosphere at home such an absence of moral control among the class of people from whom their patients are derived that the child had not a chance. The parents, instead of correcting the children when movements were seen, allowed them to go on, and in fact rather encouraged them than otherwise by petting and spoiling them in every possible way. Therefore the moment the patient goes into the hospital ward, the domestic surroundings being absent, the child is immediately under a better moral influence, and that alone warrants one in giving no medicine at all. I often induce the nurses to undertake the cultivation of the will power of the patient. This is best done by telling the child to sit perfectly still with the hands stretched out in front and the fingers very nearly touching, to put the tongue out and keep it out, to close the eyes and keep them closed, or open them and keep them open, and so on. I would strongly urge that in many cases this plan is very well worth a trial. There is a radical difference in cases of the genuine cardiac or rheumatic type, where drug treatment is all-powerful.

Most authorities tell us to first try intra-uterine irrigations of Thiersch solution, followed by normal saline solution in the *treatment of pelvic inflammation*. In this I am frank to say I do not agree, but instead I use a 1-4000 bichloride solution followed by the salt solution. I then pack the uterus full of 10 per cent. iodoform gauze. If the symptoms show improvement I allow this packing to remain 48

hours, when I remove it and repack another 48 hours, when I remove the packing and put the patient on suitable tonics. But if this fails to subdue the symptoms in 24 hours I curette, wash out the uterus with bichloride, pack as before, and open the cul-de-sac, for I take it for granted that the germs have by this time made their way through the lymphatics and attacked the adnexa, and the curettement has only served to check the process within the uterus and we have done nothing to relieve the conditions of the surrounding organs and tissues that may later necessitate a dangerous operation.

I repeat it is our duty to open the cul-de-sac in cases where we curette for septic endometritis; this permits us to break up adhesions, separate parts that are matted together with lymph, and open the lymph space so they may discharge into the dressing and receive the antiseptic in the form of free iodine, liberated by iodoform dressing, which should be used freely in the pelvic cavity made accessible by the opening. Proof of the necessity for this procedure is to be found in the amount of muddy bacteria-laden serum, which will escape during the first 24 hours, while if we should stop at the curettement we would leave our patient in a condition that would eventually lead to peritonitis, ovarian abscess, or the so-called "pelvic cellulitis,"—which I am doubtful ever exists except in the stroma of the ovary. Other cases called pelvic cellulitis are lymphangitis, the process taking place in the lymphatic structures.

But with this treatment in full your patient will leave her bed without that feeling of weight and the consequent train of nervous disorders so frequently met with. The cul-de-sac operation is simple, easily performed, and of no additional danger to the patient and of great value to the reputation of the attending physician.—H. S. Gordon, M. D., Westminster, Cal.

There is a general advocacy of *laparotomy for typhoid perforation*. I did a general practice for a number of years, and can recall two or three deaths from perforation in typhoid fever, usually in the third week, and these cases did not seem to me from my present experience in abdominal work to be in a condition to withstand any surgical procedure. To have done an operation as extensive as an intestinal resection would have been out of the question. It never impressed me that the dictum now put out over the country that every case of typhoid fever with perforation should be subjected to an immediate laparotomy was good advice. It is well to take into consideration, in connection with abdominal as well as other surgery, that it is bad surgery to operate upon all people who are going to die anyway. It

is sometimes better to let the patient that you know is going to die go on and die without the operation. In the discussion before the Southern Surgical Association about a year ago, some said: Suppose you have a mortality of 90 per cent.—for a time it was, it is now about 60 per cent.; but suppose it is 90 per cent.—without the operation, all these patients die. I know that all cases of perforation from typhoid fever do not die. I know I have seen three cases of circumscribed peritonitis, perforation from typhoid fever, with adhesions to the peritoneum, subsequent formation of abscesses, which were opened and the patients recovered. So it is not true that all cases of typhoid perforation die. To subject a patient to the operation of laparotomy in this state, you must admit, adds something to the gravity of his condition. Any person who has gone through three or four weeks of typhoid fever is not a favorable subject for laparotomy, and to say that all such patients should be subjected to the operation is an extravagant statement. In fact, the cases of perforation that should be subjected to the operation are very few indeed. The question to be considered is that some of these cases do get well, and I am satisfied the cases that do not get well would not be saved by the operation, unless the patient was possessed of great vitality, and unless the operation was performed within four or five hours after perforation occurred.—A. M. Cartlidge, M. D., Louisville, Ky.

My treatment of eight cases of *acute cervical lymphadenitis* in children (glandular fever does not furnish much material for deductions, but it seems that emphasis may justly be laid on the value of twenty-five per cent. ichthyol ointment when applied thoroughly and persistently. Its influence seemed to be not only in the direction of shortening the course of the adenitis but, in severe cases, of preventing suppuration. While it must be admitted that suppuration is not the regular event, such a termination has been reported, and in these cases it seemed inevitable.—Alfred Hand, Jr., M. D., Philadelphia.

While the treatment of fractures solely by massage, as has been advocated abroad, is not to be advised, it is undoubtedly true that massage is not employed in this country in the treatment of fractures to anything like the extent it should be. Fractures are allowed to remain in splints or plaster for weeks without any attempt being made to prevent stiffness by the use of massage.

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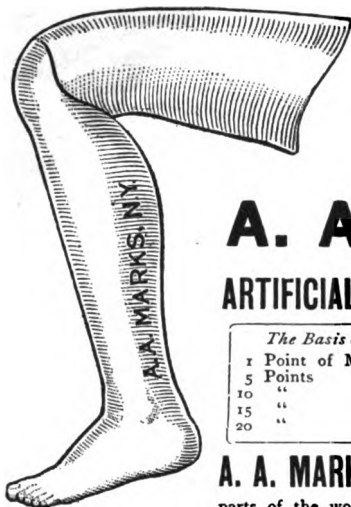
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ARCHIVES OF GYNECOLOGY, OBSTETRICS, AND PEDIATRICS.

*An Appreciation of Pryor's Method of Removing the Fibroid Uterus by the Abdomen, with Report of Ten Successive Successful Cases.**

A. LAPTHORN SMITH, B. A., M. D., M. R. C. S.

ENGLAND,

Fellow of the American and British Gynecological Societies, Professor of Clinical Gynecology in Bishop's University, Gynecologist to the Montreal Dispensary, Consulting Gynecologist to the Women's Hospital, Surgeon-in-chief of the Samaritan Free Hospital for Women, Surgeon to the Western Hospital, Montreal, Canada.

Twenty years ago he was strongly opposed to the operative treatment of fibroids on account of the high mortality then prevailing among the best operators. Ten years ago he became a strong advocate of Apostoli's method of treatment by electricity, by which he has cured the hemorrhage permanently in 63 out of 102 cases in ten years. Eight years ago Price lowered the mortality enough to induce him to operate in certain cases with the *serre noeud*. Baer farther reduced the mortality, and he adopted his method and operated oftener. Three years ago Pryor perfected an ideal method, which had almost no mortality, and which he (Lapthorn Smith) had adopted, and to which he gave the preference over all other treatment in every case of fibroid suffering enough to consult him. He claimed that he had acted consistently throughout, being guided by the one test question, "What is the mortality?" In his last ten successive cases, seven last and three this year, all had recovered. Therefore the operation is now almost devoid of danger, while it was absolutely effective. Pryor's method is by far the best, and to it was due, he believes, his absence of mortality in these ten cases. The great advantage of Pryor's method is that we begin on the easy side, and after securely tying the ovarian round ligament and uterine arteries, and separating the bladder, we cut across the cervix and roll the tumor out, thus obtaining plenty of room to tie the arteries from below upward. Another great advantage of this method is that there is much less danger of injuring the ureters. This accident is most likely to happen on the most difficult side, that is the side where the tumor fills all the space between the uterus and the wall of the pelvis. But it is precisely on this side that

the tumor is dragged away from the ureter while it is being rolled out, and by the time that it becomes necessary to cut anything on that side the ureter is at least two inches away, and quite out of danger. But Doyen's method has this advantage on both sides, because he pulls the tumor off the bladder and ureters, and from the first he is getting further and further away from the bladder and ureters. But Doyen's method has the great objection of opening the vagina, and thereby increasing time of anaesthesia, loss of blood, and risk of infection, besides the anaesthetic one of shortening the vagina. The author lays even greater stress than Pryor does upon the importance of feeling for each individual artery and tying it before cutting it, and then putting a second ligature on it, as the first one may loosen after the tension of the tumor has been removed. He also strongly advises chromicized catgut, prepared by the operator himself, or else red cross cumol catgut, prepared by Johnston of New Brunswick, N. J., which he has found reliable. Besides the six principal arteries there are two small arteries which require tying on each side of the cervix. There is no need of disinfecting the stump, beyond wiping away the little plug of mucus; but the cervix should be hollowed out so as to make an anterior and posterior flap, which are securely brought together before sewing up the peritoneum. The omentum, if long enough, should be brought down to meet this line of suture, thereby preventing the intestines from sticking to it or to the abdominal incision. The author is opposed to leaving the ovaries and tubes, although he admits that in young women by so doing it diminishes the discomforts of the premature menopause. But in the majority of cases the appendages are diseased, and we run the risk of the whole success of the operation being marred by leaving the organs, which sooner or later will cause more symptoms than did the fibroid itself. His experience of leaving in ovaries or parts of ovaries have been most unfortunate, having received no thanks for his conscientious endeavors, but a great deal of blame for having failed to cure the pain, which in the patient's estimation was more important than the tumor.

He was also opposed to myomectomy; the operation was quite as dangerous as hysterectomy; there was very seldom any reason for it, most of the women who have fibroids being either unmarried or at an age too advanced to raise children to advantage, or having passed the child-bearing age. After submitting to such a serious operation the patient has a right to be

* Author's abstract of paper read before the American Gynecological Society at Washington, May 1, 1900.

guaranteed against a second or a third one for the same disease. So many women have been disappointed by these incomplete or so-called conservative operations, that their friends who really could be cured by an operation hesitate to undergo it. He would make an exception, of course, in case of there being apparently only a single polypus, no matter how large, or a single pedunculated subperitoneal tumor.

He held the opinion that all fibroid uteri should be removed as soon as discovered, because the woman with a fibroid is liable not only to the hemorrhage, which may not be great, but to the reflex disturbances of digestion and circulation. Besides, every day it grows its removal is becoming more dangerous, and the chances of its becoming malignant are greater.

He was opposed to a preliminary curetting, because it was unnecessary, and second because when done it was seldom done effectually; having examined fibroid uteri immediately after removal, which had been curetted just before, he had found only about a twentieth part of the uterine mucosa removed.

He was strongly opposed to morcelllement, which is not to be compared with Pryor's method. It is more dangerous, much more difficult, and keeps the patient a much longer time under the anæsthetic. The operation is carried on in the dark, and the ureters are frequently wounded, and complications, such as adhesions of the vermiform appendix and tears of the intestine, which are easily dealt with by the abdomen, with the patients in the Trendelenburg posture are almost impossible to manage when working from the vagina. Moreover, nearly all women with fibroids are nulliparous, and the vagina is consequently narrow; they are nearly all elderly, and the passage is consequently inextensible. No more unsuitable class of patients could therefore be chosen for this most difficult vaginal work. The author strongly advises the closure of the abdomen with through-and-through silk worm-gut sutures, left for three or, better still, four weeks. If not tied too tightly, and if dressed with boracic acid in abundance, the one dressing or, at most, two will suffice from the beginning of the case. Besides they can be passed very quickly, thus saving ten minutes in the duration of the anæsthesia.

♦ ♦

Some New Methods in Pelvic Operations in the Female.

Mr. Rutherford Morison read a paper on this subject before the British Gynecological Society. The operations considered were as follows: 1. Abdominal resection of the sigmoid or upper

portion of the rectum.—This operation was intended for cases in which suppuration of the left uterine appendages involved the bowel to such an extent as to demand its removal, or in which the abdomen was opened for a cancerous growth of the sigmoid in mistaken diagnosis for a diseased and enlarged ovary. The steps of the operation were:

(1) The diseased bowel is excised; (2) a glass bobbin with indiarubber tube attached is tied tightly into the upper end of the sigmoid flexure; (3) the indiarubber tube is passed down from above through the lower cut end into the rectum, where it is aided to pass through the anus by the finger of an assistant; (4) the tube is drawn upon till the ligature on the upper cut end of the bowel is inside of the lower cut end of the bowel; (5) a ligature is then passed round, immediately below the lower cut end, and tightly tied; this makes the junction watertight; (6) the tube is again pulled upon, while the lower portion of the bowel immediately below the button is steadied till by traction from above a short intussusception is produced. This is maintained by a few Lembert sutures. In four to eight days the ligatured sloughing bowel separates, and the tube is thus released.

He had done this operation 14 times, in 2 cases for complicated pyosalpinx, and in 12 for malignant disease; 7 died; the percentage mortality was therefore high, but might be diminished by avoiding the mistake he had made of performing this operation in cases of obstruction with loaded colon, for experience had taught him that in these cases the colon should be emptied by a preliminary colotomy before a radical operation was attempted.

2. An operation for certain forms of parametric abscess.—Mr. Morison divided cases of pelvic cellulitis into three classes: (a) The floor of the broad ligament is involved; the abscess points toward the vagina. (b) The cellular tissue of the broad ligament between its peritoneal folds is invaded; the abscess points above Poupart's ligament. (c) The lymphatic vessels and glands alongside the iliac vessels are affected, and the abscess is found high upon the back wall of the pelvis, or in relation to the psoas and iliacus muscles. In the third form the pus was out of reach from the vagina, and having had two fatal cases in which he evacuated the pus by opening the abdomen, he devised the following plan:

The abdomen is opened by an incision 3 or 4 inches long, made in the middle third of a line drawn from the center of the back of the ilio-costal space behind to 1 inch above the symphysis in front. Through this incision the diagnosis is confirmed by palpation of the uterus, ovaries, and tubes, and the relations of the abscess are ascertained. The incision is next prolonged

to the back of the ilio-costal space, through the oblique and transversalis muscles, leaving the transversalis fascia and peritoneum intact. The peritoneum and fascia are then held forward with forceps, and with the left hand in the abdomen as a guide, the index finger of the right hand introduced posteriorly opens the abscess by bluntly perforating the transversalis fascia under the thickest part of the swelling. A drainage tube and iodoform gauze packing round it complete this part of the operation.

♦ ♦

The Treatment of Diphtheria by Iodine.

HUGH TAYLOR, M. D., WREXHAM.

It is now more than a quarter of a century since I began to treat this disease with iodine. During my professional career I have had a great number of cases to treat, and my faith in the curative power of iodine is very great, for since I adopted it my fatal cases have not numbered more than two. I regret that I have no record of the exact number of cases, but among them there have been severe and mild ones, occurring in young and old.

On being called to a case I generally give a good dose of calomel. I paint the throat, tonsils, back of pharynx and uvula well with the tincture of iodine by means of a camel's-hair brush or a swab of cotton wool, and I advise the repeated inhalation of the tincture of iodine in hot water—about one teaspoonful of the tincture in a quarter of a pint of hot water—for about five minutes at a time every half hour or so, or even in severe cases more frequently.

The good effect of this is soon seen by the quick arrest of the fetor of the breath, and in a short time by the peeling off of the membrane. The inhalation must be well done; and I advise my patients to inhale through the nose and throat, by which means the vapor of the iodine is thoroughly carried through the nasal passages and throat to the lungs, etc.—a most important matter.

I saw a very severe case some short time ago late at night, and fortunately I had with me some tincture of iodine which I promptly applied without dilution to the back of the patient's throat, uvula, pharynx, and tonsils, and told him to inhale repeatedly the iodine vapor. The next day I went prepared to inject antidiphtheria serum, but I found him so much better that it was unnecessary to do so. The membrane had nearly all peeled off the parts attacked, and he expressed himself—to use his own words—"a different creature." I advised him to continue the inhalation, but not so frequently, and painted his

throat again. He soon got well. In addition to this treatment, I always give quinine and the tincture of the perchloride of iron, brandy and port wine as required, with plenty of beef-tea and such things. I also sometimes give small doses of the tincture of iodine internally, but I do not often find this necessary, and volatilize on a hot shovel some grains of iodine for disinfection of the air in the room. I believe it is owing to the strong deodorizing, antiseptic, and disinfectant properties of iodine that such good results accrue from its use.

I am one of those who entertain the belief that diphtheria commences in the throat, and that the general system is rapidly affected afterwards, thus necessitating the prompt application of treatment to the membranous exudations on the fauces, so as to prevent as much as possible the infection of the whole system.

♦ ♦

Subcutaneous Symphysiotomy.

Dr. G. Ernest Herman read a paper on above subject, pointing out the advantages of the subcutaneous operation, especially as regards its simplicity, quickness, small risk of sepsis, insignificant hemorrhage, absence of a gaping wound and of a subsequent scar. He urged that if the maximum benefit from symphysiotomy was to be secured it should be done under the most favorable conditions. It ought not to be postponed until the necessity for some kind of operative delivery had been demonstrated by the complete failure of the natural powers. The accoucheur should ascertain the size of the pelvis before labor and estimate also the size of the child. If he decided upon symphysiotomy it should be done at the most favorable time, and that was immediately after full dilatation of the os uteri. The frequency with which in contracted pelves the membranes ruptured prematurely would make the dilatation of the cervix with Champétier de Ribes' bag usually advantageous. Dr. Herman pointed out that one risk at present inseparable from symphysiotomy was that of injury to the urethra; this was likely to happen in cases in which an attempt was made to deliver by symphysiotomy a child too large to be delivered in that way, and thus the pubic bones were excessively separated. This was to be guarded against by carefully estimating the size of the child beforehand.

Dr. Griffith described an easy method of ascertaining the relative sizes of the fetal head and the maternal pelvis. The woman was made to sit on the edge of the bed at such an angle that the long axis of the fetus was vertical. The fetal head, if smaller than the pelvis, would then spon-

taneously dip into the cavity owing to the weight of the fetus being free to act.

Dr. Lewers said he had seen some of the operations described in the paper, and he regarded subcutaneous symphysiotomy as a great improvement on the method involving a large open wound. It is not applicable, however, in all cases. In his own case of symphysiotomy, for instance, there was a sort of "bite" or dovetail at the middle of the joint and a saw had to be used before the joint surfaces could be separated. His patient had incontinence of urine for some weeks after the operation, but ultimately recovered complete control in this respect and micturition was now quite normal.

Dr. Spencer thought the subcutaneous method recommended by Dr. Herman had advantages over the open method, but it was to be remembered that many cases of severe hemorrhage from division of large vessels had been recorded and this had led some authorities to advocate the open method and packing the wound with iodoform gauze. Wounds in the vagina were also very apt to occur, and if these communicated with extensive effusions about the pubes the danger of sepsis would scarcely be diminished by the subcutaneous method of dividing the joint.

Dr. Herman in reply said he was much interested in the method of ascertaining the relative size of the pelvis and child described by Dr. Griffith and hoped to put it in practice. He had included lacerations of the vagina in the injuries of the urethra of which he had spoken, for lacerations of the urethra usually affected the vagina also, and a laceration of the vagina so slight as not to reach the urethra was not important.

♦ ♦

Retroflexion of the Gravid Uterus.

Dr. W. J. Sinclair read a contribution before the Obstetrical Society of London to the diagnosis and treatment of retroflexion of the gravid uterus. In a typical case of retroflexion of the gravid uterus, he pointed out that the symptoms produced a tout ensemble which was quite characteristic, and should make diagnosis easy and certain. The striking constant feature was irritability of the bladder, with more or less retention of urine. The contributions to the journals on the diagnosis and treatment of the condition had a tendency to exaggerate the frequency of complications, and the literature of the subject seemed to indicate a too ready resort to operative treatment. The special method of treatment advocated was extremely simple. It consisted es-

entially in the introduction of a watch-spring pessary, care having previously been taken to empty the bowel and bladder. After the introduction of the pessary, if the patient was made to rest on her side, lying over with her face downwards as far as she could with comfort, it would be found that the action of the pessary alone restored the uterus to its normal position in a few hours. Illustrative cases were given. The whole number of cases in which the method of treatment had been tried by the author was 15. These had been consecutive, and in all the method of treatment had been successful. One case was mentioned in which the watch-spring pessary treatment was adopted owing to a misunderstanding in a case of fibroid tumor attached to the fundus uteri, which had fallen back into Douglas' space and produced the bladder symptoms of retroflexion of the gravid uterus. In this case the action of the pessary raised the tumor into the abdominal cavity. The question of retroflexion of the uterus as a cause of abortion was mentioned incidentally. Abdominal section, or any severe method of treatment of retroflexion of the gravid uterus, was deprecated. Ventrifixation after abortion and involution was recommended in cases of adherent retroflexed uterus.

The President agreed that retention of urine and irritability of the bladder were very important symptoms for diagnostic purposes. Of recent cases Konrad's of Buda-Pesth was interesting. Relief came too late. Sloughing of the mucous membrane of the bladder and death followed abortion, which occurred three days after reduction of the uterus. He had referred at the April meeting to Unterberger's case, where the displaced pregnant uterus obstructed the bladder and forced open the urachus. Lastly, he dwelt on Gemmell's case, at Liverpool, where a woman was seized with abdominal pain and retention of urine at the third month, and backward displacement of the gravid uterus was suspected. The mass in the pelvis, however, was found to be a fibroid, which was enucleated through an abdominal incision. Pregnancy continued to term. As to difficulty in keeping the reduced uterus in place, the President referred to Szanto's case where the displacement was attributed to relaxation of the supports of the uterus, caused by typhoid fever; the uterus was replaced manually. Under such circumstances recurrence of the displacement was no doubt very probable.

Dr. Inglis Parsons had found that the air-ball pessary answered very well. He preferred this gradual method to the more rapid method of manual reposition, because it was less likely to produce abortion. Cases of retroversion bound

down by adhesions were not at all common; he had never come across a case of this kind in which pregnancy had occurred. If confronted with this complication he would prefer to open the abdomen, free the adhesions, and hope the pregnancy would go to term.

Dr. Galabin thought Professor Sinclair's paper was valuable in calling attention to a mode of treatment the value of which would seem not to have been duly appreciated, provided that it proved as successful in the hands of others as in those of the author. He did not think, however, that this treatment ought to supersede the even simpler one of immediate taxis. He was accustomed to place the patient in the knee-elbow position and apply pressure to the fundus, first from the vagina, then, if that failed, from the rectum. His experience was that an anæsthetic was not required in one case out of twenty. He had been accustomed, twenty-five years ago, to restore retroversions of the gravid uterus in the out-patient room without even admitting the patients to the hospital. In some cases, however, an anæsthetic alone rendered the taxis practicable. He had never finally failed to reduce a uterus, nor had found it necessary to induce abortion, and for many years had employed nothing but immediate taxis. His experience, therefore, strongly confirmed Professor Sinclair's view that firm adhesions in connection with retroversions of the gravid uterus were very rare. He had not found abortion follow immediate taxis, but had known it occur during the use of elastic pressure. He had not employed the watch-spring pessaries as a primary treatment, but had always employed them both for keeping up the uterus when restored and in cases in which the restoration at first did not appear quite perfect. In future he should certainly try the plan when restoration could not be effected without an anæsthetic. As regarded the mechanism of the pessary, he attached even more importance to a leverage which Professor Sinclair had not mentioned than to the one which he did mention. This resulted from the traction on the cervix produced by stretching backward the posterior vaginal fornix. In this case the uterus itself was the lever, the fulcrum was the position of the internal os, where the uterus was most fixed by its ligaments, and the dragging of the cervix backward tended to tilt the fundus forward.

Dr. Drummond Robinson referred to a case of incarcerated retroverted gravid uterus, which he had seen when he was clinical clerk to the late Dr. Matthews Duncan:

The patient, aged twenty-four, was pregnant for the first time, had retention of urine on

November 6, soon followed by constant dribbling of urine. On November 28 nine pints of ammoniacal urine were drawn off by catheter. On December 6, after many unsuccessful attempts to replace the retroverted gravid uterus, Dr. Duncan induced abortion. On December 5 protrusion and redness of the umbilicus was noticed, and a few hours afterwards offensive urine began to ooze from it; this continued until the patient's death on December 20. The mucous membrane of the bladder began to slough and to be passed per urethram, soon after the patient's admission to hospital. At the post-mortem examination the mucous membrane of the bladder was almost completely absent, and the bladder communicated with a fistula at the umbilicus. The uterus was not adherent in Douglas' pouch. The right broad ligament contained an abscess.

Dr. Duncan stated that he had never previously been obliged to induce abortion for this condition.

Dr. Boxall thought they were much indebted to Professor Sinclair for drawing attention to the fact that abdominal section or any severe method of treatment was rarely called for. For his part, he had never met with a case which would not yield to well-directed pressure, and he doubted if anyone present had met with a case which necessitated even puncture before the uterus would be replaced. He regarded chloroform as useful in enabling the reduction to be effected with less force, and consequently with less danger of producing abortion, than when no anæsthetic was given.

Dr. Ewen Maclean cited a case of retroverted gravid uterus at the fourth month in a primipara. The symptoms were urgent, and, the usual manipulations failing, the patient was admitted to hospital with a view to the administration of an anæsthetic. After left decubitus, however, for several hours, the uterus suddenly reduced itself into its normal position.

♦ ♦ ♦

A Case of Complete Inversion of the Uterus.

DAVID DURRAN, M. B. GLASG.

Owing to its great rarity the following case of complete inversion of the uterus ought to be placed on record. Various explanations have been given to account for its production. In the present case there was a suspicion that pressure on the abdomen was improperly applied, but the midwife who was in attendance would not admit

that there was undue pulling on the cord. The case was as follows.

On January 30, 1899, I was called to a woman in labor. On my arrival I found her in bed, pale, with a small and feeble pulse, cold clammy skin, and evidently suffering from shock. The midwife informed me that a little over an hour before a child was born, and that along with the after-birth something came down the like of which she had never seen before, but which she thought was the womb. This she returned. There was great loss of blood, and the patient had been in a fainting condition ever since. It may be mentioned here that the patient was 25 years of age, strong, and in good health. She had been married seven years and this was her third child. On examination I discovered a large globular mass of the consistence of muscle tissue filling the vagina and bleeding profusely. Bimanual examination showed the absence of the contracted uterus, and instead a cup-shaped depression was easily felt, which made out the case to be one of complete inversion of the uterus. Manipulation restored the organ in a few minutes to its natural condition. The inverted uterus was first firmly grasped by the hand and gently squeezed, being at the same time pushed slightly upwards. The tips of the fingers were then applied to the fundus, and by steady pressure in the proper axis of the pelvis the uterus was felt to resume its natural shape. The patient made a good recovery and everything went on well until the eleventh day after the confinement, when delusions showed themselves, and in a few days the case developed into one of acute puerperal mania, presenting the usual symptoms, which necessitated asylum treatment. There was evidence of hereditary tendency, but the determining cause at that time was no doubt the shock from the accident referred to as well as exhaustion from the great loss of blood. After several months in the asylum the patient returned home and is now in very good health.

• •

A Drop of Oplate for the Baby.

An inquest was held recently upon the body of an infant, the child of a laborer, at which evidence was given to the effect that on the evening of the day upon which the mother was confined the newly born child was "restless"—a not uncommon circumstance with infants—and that a neighbor, apparently at the mother's request, administered to the child an unknown quantity, defined by her as a few drops, of the anodyne medicine prescribed by the medical man in attendance for the use of the mother, who was in considerable pain.

From the evidence given by the neighbor in question and the father of the child it further appeared that the administering to "restless" infants of opiates, which happen at the time of confinement to be conveniently at hand, is by no means uncommon; indeed, it seemed to be regarded by them as a natural and perfectly harmless means of securing tranquillity. That in the district in question, at all events, it amounted to a customary practice appeared also from the evidence of Mr. R. G. Coombe, the medical man who had attended the mother. It seems to have been unknown to him before the occurrence that formed the subject of the inquiry, but he had evidently been at some trouble to inform himself with regard to it, and the coroner and he alike were emphatic in denouncing it as dangerous in the highest degree. Guided by the coroner, who pointed out that there was no evidence that anyone intended to injure the child, the jury returned a verdict of "Death from misadventure," adding a quaint rider to their verdict (which was received by the public with applause) to the effect that the mother, from what they knew of her, was not likely to have administered the opium intentionally, as she was a good mother to her children. This we cannot gainsay; but good mother or not, she may be reckoned as a fortunate one, while her friend is also to be congratulated.

To have administered poison intentionally, thereby killing the child, would have brought the person responsible perilously near to the crime of murder, but that which constitutes murder when done of malice prepense, when it is found to arise from culpable negligence, constitutes manslaughter. The ignorance of the persons in the case before us, or their good character, may have entitled them to profit by the verdict found, but it must be borne in mind in considering similar cases that mothers to whom anodynes are administered know the purpose for which they take the medicine and its effect upon themselves, and that if, knowing this, they infer that "a few drops" will have a quieting effect upon their children, they must almost necessarily be taken to have enough intelligence to know that it is possible to give a dangerous overdose. It is certainly also desirable that the medical man who prescribes an opiate for the mother after her confinement should warn those about her not to administer even the smallest quantity of it to the infant, and should further see that there will be as little as possible of it about the house to act as a temptation to the reckless or the ignorant.

In seeking the cause of renal colic the X-rays have given very unsatisfactory results in proving the presence or absence of a calculus.



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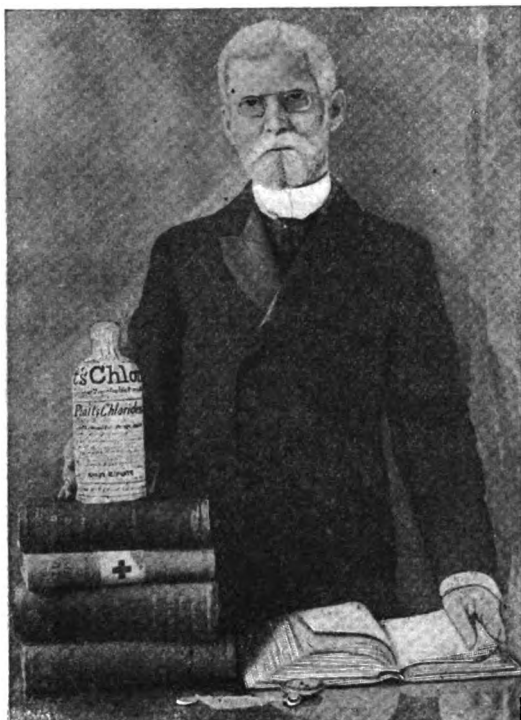
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(W. R. WARNER & CO.)

R Phosphorus, Ferri Carb., Asafetida, Ext. Sumbul, Ext. Nux Vomica,	1-100 gr. 1 1/4 grs. 1/2 gr. 1/2 gr. 1-10 gr.
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DOSE: 2 tablets before meals for adults.

In Tono-nervine Tablets we offer a combination of well-known nerve tonics and stimulants. It is a tablet that will cover a wide field of usefulness in physicians' prescribing. When the indications are for a prescription to correct conditions due to asthenia, neurasthenia, or nerve exhaustion, whether the result of debilitating diseases or excesses, you have in Tono-nervine Tablets a remedy which will give satisfactory results.

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A tablet dropped in a glass of water will afford a sparkling draught which should be drunk during effervescence. The claim for preference of the "Warner" method for the administration of Lithia are based upon the following: An accurate and definite amount of Lithia in each dose. Economy, convenience, and general elegance of the remedy. Absolute medicinal effect. These tablets should be obtainable from all druggists.

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HIGHEST AWARD WORLD'S FAIR, OCT. 4TH, 1893.



Fig. V—Semi-Reclining.

- 1st. Raised by foot and lowered by automatic device.—Fig. I.
- 2nd. Raising and lowering without revolving the upper part of the chair.—Fig. VII.
- 3rd. Obtaining height of 80 1/2 inches.—Fig. VII.
- 4th. As strong in the highest, as when in the lowest position.—Fig. VII.
- 5th. Raised, lowered, tilted or rotated without disturbing patient.
- 6th. Heavy steel springs to balance the chair.
- 7th. Arm Rests not dependent on the back for support.—Fig. VII—always ready for use; pushed back when using stirrups.—Fig. XVII—may be placed at and away from side of chair, forming a side table for Sim's position.—Fig. XIII.
- 8th. Quickest and easiest operated and most substantially secured in positions.
- 9th. The leg and foot rests folded out of the operator's way at any time.—Figs. XI, XV and XVII.
- 10th. Head Rest universal in adjustment, with a range of from 14 inches above seat to 12 inches above back of chair, furnishing a perfect support in Dorsal or Sim's position.—Figs. XIII and XV.
- 11th. Affording unlimited modifications of positions.
- 12th. Stability and firmness while being raised and rotated.
- 13th. Only successful Dorsal position without moving patient.
- 14th. Broad turntable upon which to rotate the chair, which cannot be bent or twisted.
- 15th. Stands upon its own merits and not upon the reputation of others.



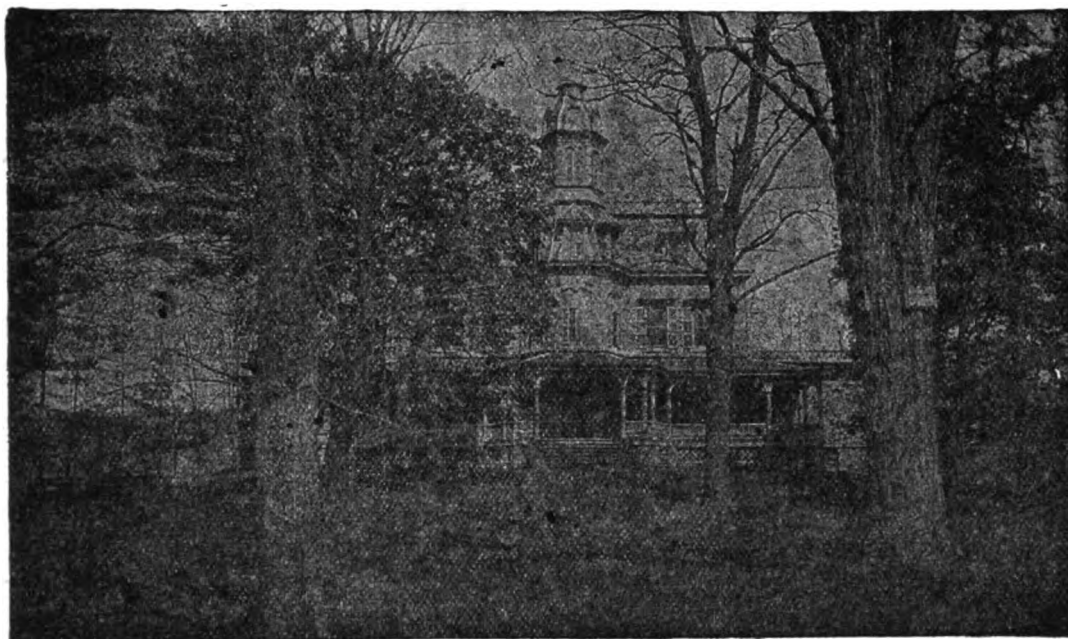
Fig. XVII—Dorsal Position.

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3.25 P. M.—WASHINGTON AND CHATTANOOGA LIMITED, VIA LYNCHBURG AND BRISTOL. Pullman Drawing Room Sleeping Cars, New York to Roanoke, Knoxville, Chattanooga, New Orleans, and Memphis. Dining Car service.

4.25 P. M.—WASHINGTON AND SOUTHWESTERN LIMITED. Pullman Drawing Room Sleeping Cars, New York to Atlanta, Macon, New Orleans, Birmingham, Memphis, Asheville, Knoxville, Chattanooga, and Nashville. Dining Car service. Tuesdays, Thursdays, and Saturdays Sunset Limited connection.

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This Company is not in debt. Under a guarantee of the Company, all the stock is non-assessable. The Board of Directors agree with every purchaser of stock, that the mines will be kept free from debt; that no expense of any kind shall be incurred beyond the limit of the funds on hand; that, in short, under no circumstances will there ever be an assessment levied on the stock for any purpose whatever. They invite the public to join in this enterprise.

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